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# NEW JERSEY MEDICINE

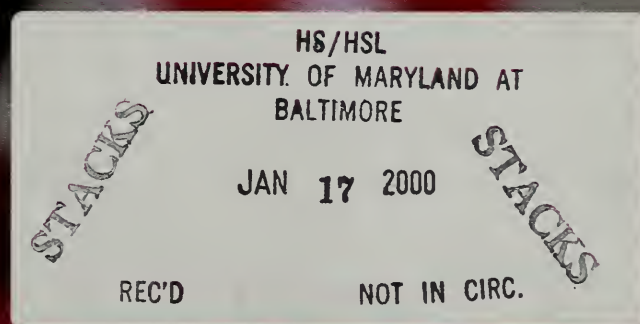
HEALTH CARE IN THE GARDEN STATE

JANUARY 2000

## Jayne LaVecchia

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## Already old in the new millenium?

Capitation generally and open-access plans specifically are limping, not leaping, into the new century, judging from reports summarized in the *Healthcare Leadership Review*. "Even on the West Coast," intones the newsletter, "capitation is stalling."

According to the writers, health plans that offer open access to specialists succeed only when there are strong risk-sharing incentives, rewards for adhering to clinical protocols, and other effective management techniques.

The review quotes Brent Greenwood, principal at Towers Perrin IHC, as warning that the health care system is stumbling toward an indemnity approach with substantial deductibles and co-pays and significantly less reimbursement for physicians. Greenwood favors a more "patient-centered" approach.

**DURABLES AND DENIALS.** Offering advice for physicians and others, the review suggests that health care providers apply the marketing concept of "durable value." Unlike

consumables, durable goods furnish value to the consumer over time. Consider, for example, a hip replacement, stroke prevention, or stress reduction.

The main advantage to health professionals of a durable-value concept lies in the importance to the consumer of a lasting relationship. The Cleveland Clinic demonstrates use of the concept by giving employers and employees an annual health risk assessment report.

In another piece, the *Healthcare Leadership Review* suggests that HMOs may start to deny more claims, at least initially. Price-waterhouseCoopers calculates that HMOs could generate \$280 million a year in interest income by denying one percent of claims, then paying the claim following an appeal or independent review.

We're not so cynical as to suggest that HMOs actually would revert to a tactic like that. We merely report what a prominent accounting firm is saying.

**FIGHTING SMOKE AND MIRRORS.** Why should New Jersey spend 25 percent of its tobacco settlement rev-

enue on tobacco control? Matthew Myers, new head of the national Campaign for Tobacco-free Kids, told a state house legislative conference convened by Department of Health and Senior Services Commissioner Christine Grant that coordinated, intensively funded efforts in California and Massachusetts have cut smoking rates significantly, which will save thousands of lives in each state.

**O**ne millennial change is the assumption by Kim Horan Kelly of the position of executive editor and Web site manager of the Medical Society of New Jersey. Kelly has extensive experience in scientific publishing. She and *New Jersey Medicine* editor-in-chief Paul J. Hirsch, MD, are intensifying this publication's focus on health policy in the Garden State. Reach her at [kkelly@msnj.org](mailto:kkelly@msnj.org).

For example, Myers noted, such efforts have reduced smoking by pregnant women by as much as 45 percent. Smoking during pregnancy is a major cause of infant mortality—as well as huge public expenditures for treating low-birth-weight babies.

He observed that substantial state expenditures on counter

advertising are needed to offset the tobacco industry's annual \$5.5 billion annual outlay on marketing. Despite industry claims to the contrary, much of this money is intended to attract kids to tobacco.

**STANDING UP.** Six other New Jersey congressmen signed a letter penned by Representative Robert Andrews to implore the House Ways and Means Committee to help correct inadequate Medicare reimbursement for physicians.

The worthy group consists of Andrews's fellow Democrats Bill Pascrell, Jr., Donald Payne, and Steve Rothman, and Republicans Frank LoBiondo, Jim Saxton, and Christopher Smith.

**DISCORD OVER MODEL.** New Jersey's Individual Health Coverage Program drew controversy in the letters column of *Health Affairs*. Katherine Swartz of Harvard and Deborah W. Garnick of Brandeis had written in praise of the model program, which seeks to cover otherwise uninsured people through standard, highly regulated, but competitively priced insurance products.

Calling the Swartz-Garnick piece a "truly classic example of obfuscation," Lee D. Tooman, Jr., of Golden Rule Insurance Company says that premiums charged by insurers in the program are "out-

rageously high" and led to a 23-percent drop in coverage between 1995 and 1997. The individual program, claims Toomey, is a "dismal failure."

The authors respond that the program saved an individual market that was about to collapse. They add that the New Jersey effort preserves the virtues of competition in a market that many people find unaffordable.

**DIALING UP.** In another move to expand health care coverage, New Jersey continues to promote aggressively its KidCare program. The HMO-based effort is designed to bring children into the health care system at affordable premium rates.

State officials are asking physicians to familiarize patients with the program. Information about KidCare is available by phone (through multilingual operators) at (800) 701-0710, or online at [www.njkidcare.org](http://www.njkidcare.org).

**E-PROGRESS.** The push toward electronic transactions is engulfing the attention of Aetna US Healthcare executives. CEO Richard L. Huber calls Aetna's E-Health program "another example of our dedication to improving our relationship with physicians. I want to be able to pay them quickly," he assures

economist James C. Robinson in a *Health Affairs* interview.

Huber also is interested in connecting claims data to clinical information. If successful, this will be a remarkable step forward in health care database management. (If not generally successful, the move will actualize one New Jersey physician's recent foray into the world of haiku: "Three things are certain:/Death, taxes, and lost data./Guess which has occurred.")

**MOVING UP.** One of the US Congress's three top advocates of pro-physician legislation (Representatives Tom Campbell of California, Charlie Norwood, DDS, of Georgia or perhaps Greg Ganske, MD, of Iowa) is expected to speak at Physicians Conference 2000, New Jersey's landmark convention planned for May 5-7 in Atlantic City. All have drawn rave reviews at recent AMA meetings.

Indeed, the full line-up of speakers at the May event promises to be national in import and presentation skills. Unique in format in the entire country, the conference is sponsored by the Medical Society of New Jersey and, so far, 35 other medically oriented organizations. *Hint:* Write "Newswatch" on your conference registration form.

Neil E. Weisfeld



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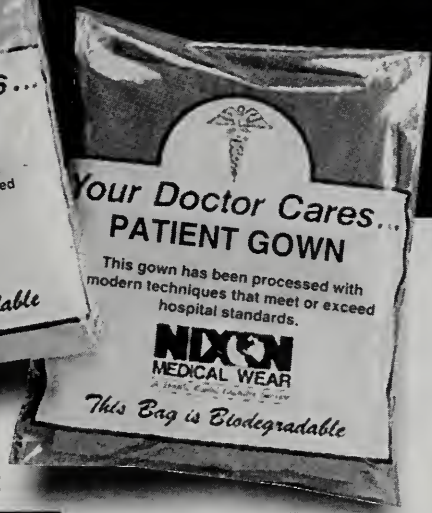
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George T. Hare, MD, FACP; Susan C. Reinhard, RN, PhD; Jane H. Brick, MSN, RN, NPC; Carl Tepper, RPh, FASCP, CCP; Martin T. Zanna, MD, MPH

The second of a two-part series that focuses on reducing polypharmacy and adverse drug events in the community-dwelling elderly. This month: the medical exception process system and how it works.

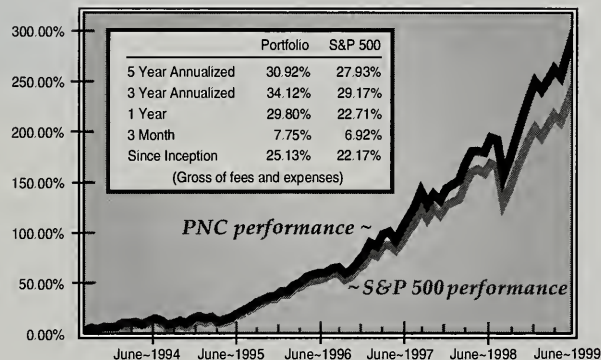
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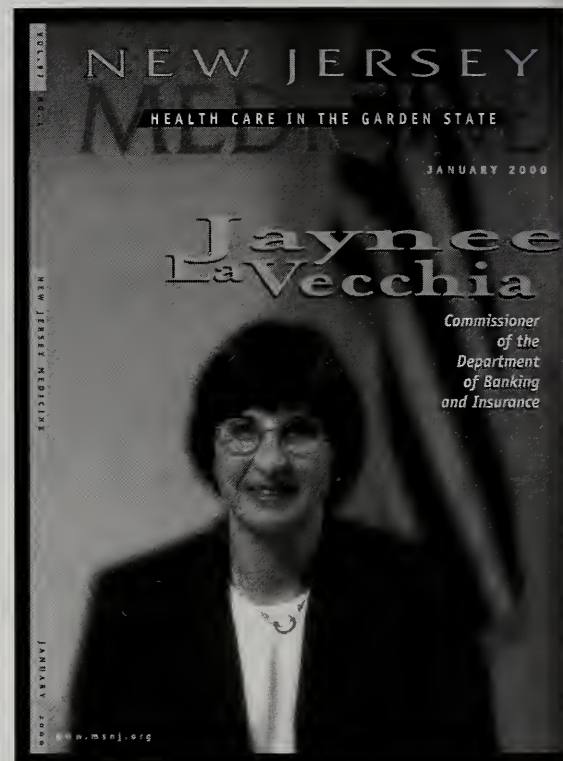
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Cover © Conrad Gloos

**Erratum:** "Good News on Managed Care," by Rep. Rob Andrews, was inadvertently left out of December's table of contents. It will be correctly indexed on the MSNJ Web site.

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## CHANGES

There have been a number of recent changes in our publication: in the articles that we publish and in the way that we function.

It is now, as always, our intent to publish information about the activities and programs of the Medical Society of New Jersey. We are also providing an increasing number of articles that relate to health care, the delivery of health care, medical practice, and practice management.

Some changes you may have noted recently include regular reports by New Jersey legislators, practice management articles, monthly interviews with health policy decision-makers, and coverage of biomedical ethics. Last month we resumed an obituary section, reporting recent deaths of members of the Medical Society of New Jersey; this had been discontinued in the past and has been among our most frequent requests. We plan to publish this listing, with an occasional extended obituary, on a quarterly basis.

Beginning with this issue, we are instituting on the last page a feature we have called "Reflections." We invite your submissions on any of your experiences in life or any topic of personal interest. The first column in the series is by Dr. Bernard Robins. We expect to alternate this feature with "Photo Finish."

We are also changing in other, less obvious, ways.

In the past, *New Jersey Medicine* has had a single editor, working with the staff at the Medical Society. That is no longer possible. The broad range of issues that face us requires an editorial staff, rather than one editor working alone. For the first time, *New Jersey Medicine* has a Board of Editors, consisting of Associate Editors and Emeritus Editors, each with specific and identifiable expertise and experience.

At a recent meeting of the Editorial Board, a publication strategic plan was adopted to serve as a guideline for those working on the publication and to provide a standard for the Board of Trustees and others who may wish to monitor our performance. The plan includes 11 specific goals and 30 separate measures of performance. Undoubtedly, these will change over the months ahead; a strategic plan is always a living document that evolves. And we will certainly fail at some of our objectives; if we did not, we would have set our sights too low. However, we believe that the process of identifying these goals and objectives has been a valuable exercise for the editors, and the resulting document will serve us as a roadmap as we navigate the changes in this journal.

The strategic plan has been presented to the Board of Trustees of the Medical Society, so that they may observe our progress against this standard. Any reader may obtain a copy by contacting the editor.

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*New Jersey Medicine* interviewed Commissioner LaVecchia recently, covering a wide array of topics. She discussed the HIP insolvency, Aetna's acquisition of Prudential's health plans, consolidation in the New Jersey health care market, ERISA plans, physician negotiations with insurance carriers, changes in

payments for medical care under auto insurance programs, and plans to ensure prompt payment to physicians by insurance companies.

The commissioner has a firm grasp of the areas under her regulatory authority and spoke frankly and openly. We have been impressed with her accessibility, her knowledge, her thoughtfulness, her concern about the financial strength of health plans, and her caution in applying the state's regulatory processes. We are gratified that she is also concerned about the problems that the health care system presents to physicians. Readers will be interested in Commissioner Jaynee LaVecchia's responses to our questions in the *New Jersey Medicine* Interview this month.

## "FIRST, DO NO HARM"

"To Err is Human" is the title of a recent report on medical errors issued by the Institute of Medicine (IOM). The survey indicates that preventable medical errors may cause as many as 98,000 deaths annually, in hospitals alone. The National Academy of Sciences, of which the IOM is the medical research arm, requested that Congress create an agency that would monitor medical errors and require that physicians disclose and report such errors.

The Institute of Medicine estimated that about half of all medical errors may be preventable. It did not fault individual carelessness as much as an absence of systems to catch and prevent errors.

The IOM report made headlines and rapidly prompted serious initiatives to establish a system in which errors would be studied, with a view toward preventing future similar episodes. President Clinton endorsed the study and ordered a task force to report within 60 days on measures to improve patient safety. He further ordered that health plans for federal government employees be required to

develop systems to reduce medical errors. Sen. Edward Kennedy has announced that he would introduce legislation that would codify the recommendations of the IOM.

It is no surprise to anyone that doctors sometimes make mistakes. Medicine is increasingly technological and complex. Many of the errors, however, are due to factors as simple as sloppy handwriting. The various proposals emphasize the need to learn from mistakes, the need to learn from minor errors as well as from fatal mistakes, and the need to identify system failures rather than find individual fault.

All who participate in patient care—physicians, nurses, pharmacists, administrators—should review their procedures and protocols: from handwriting to activities during surgery; from patient identification procedures when administering medication to site identification in the operating room. We are confident that physicians and all members of the health care community will recognize the importance of developing programs to effectively and reasonably implement the Institute's recommendations.



### Bringing The Politician To The Physician

Although past preference has been to keep politicians and regulators away from the practice of medicine, physicians are increasingly seeking Trenton's and Washington's intercession to counteract intrusions into the medical office. Politics and medicine get even closer at Physicians Conference 2000, through several events designed to facilitate communication among New Jersey physicians and state and federal representatives.

"More than ever, physicians must actively present their issues to government," said Joseph Reichman, MD, chair of the Conference Planning Committee. "Our opposition is usually well-funded and coordinated in their lobbying activities. While we've succeeded over the past several years in securing some legislation and regulations that protect physicians and our patients, much more needs to be done. Conference 2000 will provide an outlet to advance our agenda. Instead of having to go to Trenton or DC, however, the politicians will come to us."

Several events with political overtones have been scheduled

during the conference. Governor Whitman is invited to participate in the conference's opening session. And Christine Grant, commissioner of the Department of Health and Senior Services, will be this year's speaker at the Academy of Medicine lecture.

In addition, the Conference Task Force expects to finalize arrangements with either US Representative Charles Norwood (R-GA) or Representative Thomas Campbell (R-CA). Rep. Norwood sponsored the federal Patients' Bill of Rights, which passed the House in October and is now in conference with the Senate version. Rep. Campbell's bill, the Quality Health Care Coalition Act of 1999, would remove antitrust exemptions and allow physicians to negotiate effectively with health plans.

Another political highlight at the conference will be the Physicians Public Affairs seminar. This will be the fourth such seminar and promises to be the largest and the most broad reaching in terms of attendees and legislative representation.

"We've had tremendous interest and participation at past events," says Beverly Lynch, a lobbyist with Martin Bontempo and member of

the Conference Task Force. "This forum allows tremendous interchange between physicians, their lobbyists, and legislators. The conference occurs in the middle of the Assembly's first year of this term, and the potential to move legislation will be high. This will be an excellent time to reassess our strategies, following on the heels of the budget debate."

"The Public Affairs Seminar fits with the purpose of the conference—the opportunity for physicians to display our strength and unity of purpose," said Dr. Reichman. "Any physician that is sincerely interested in the future of our profession should be involved in these conference events."

Dr. Reichman adds that while the major presidential candidates have been invited, it is too early in the campaign for them to commit their schedule.

Following the Physicians Public Affairs Seminar will be the JEM-PAC reception, which will give physicians and legislators the opportunity to interact further in a less formal setting.

*Note: Confirmation of certain political speakers is expected by publication date. Check [www.msnj.org](http://www.msnj.org) for the latest updates.*



## CONSUMER HEALTH QUESTIONNAIRE

**A**lthough patients hold a key to their medical history, they are often the least-involved participants in their own health care. Now, on the Web site [YourOwnHealth.com](http://YourOwnHealth.com), consumers can complete (in English or Spanish) a detailed history of the present illness (HPI) on more than 100 common medical problems before seeing their physician. This procedure can take place even in the physician's or clinic's waiting room (which saves time and produces a comprehensive HPI). The HPI report also lists, alphabetically, the differentials that were triggered by patient response.

PrimeCare has contracted with the Mount Sinai School of Medicine in New York City to review and update the medical content of the HPI questionnaires.

There is no charge for access to the site or use of the questionnaires. Located at:

[www.yourownhealth.com/default.asp?medid=2046](http://www.yourownhealth.com/default.asp?medid=2046)

physicians and health care professionals can link their sites to it or distribute the address to their patients. For more information, call (973) 428-1091.

## PREVENTIVE CARE SITE

**T**he Heureka Center for Disease Prevention and Health Promotion has a

Web site run by Vernon R. Daly, MD, in Burlington NJ. The site lists the center's goals as, among others, the promotion of prevention as the primary modality of health care delivery and expanding the primary care infrastructure for all. The site has links featuring various topics, including cancer screenings, lead screenings, health expos, other health programs, and links to news sources. For more information, visit the Web site at [www.heurekacenter.org](http://www.heurekacenter.org) or call (609) 386-2676.

## CONSUMERS ASSESS THEIR HEALTH AND LIFESTYLE

**A** personal wellness profile and health risk assessment tools are now available at [www.healthanswers.com](http://www.healthanswers.com).

This new health information service allows consumers to assess their health and lifestyle through completing an interactive, Web-based form, which then gives recommendations for improvement.

The [healthanswers.com](http://healthanswers.com) personal wellness profiler features an interactive health survey and creates personal health reports. It also includes recommendations for reducing the risk of serious conditions, including cancer, osteoporosis, and heart disease and provides suggestions and tips about fitness, nutrition, stress and coping, substance use, and personal safety.

## BOOKMARKS

<http://www.doctorspage.net>

A blend of links, news, and resources to fit the daily information needs of physicians and patients in a variety of categories.

<http://www.healthgrades.com/>

Ratings of physicians, hospitals, health plans, and HMOs. This site offers a combination of report cards, directories, tools, a glossary, health news from Reuters, and a variety of health stores.

<http://www.mdlinx.com/>

This site provides specialty-focused health and medical news for internists and serves as the first of a string of similarly focused sites aimed at anesthesia, cancer, arthritis, dentistry, dermatology, and emergency medicine, among others.

<http://www.surgisource.com>

Information and resources for ambulatory surgery centers and anesthesia professionals.

[www.msnj.org](http://www.msnj.org)

Members of the Medical Society of New Jersey (MSNJ) will want to go to MSNJ's Web site every day for the latest news and perspectives.



**PEOPLE IN THE NEWS**

Several physicians from the The Valley Hospital in Ridgewood NJ recently attended and presented at the Second International Congress on New Technologies in Reproductive Medicine, Neonatology, and Gynecology, held on Sardinia Island in Italy. The group comprised **Frank P. Manginello, MD**, director of neonatology; **Charles Lockwood, MD**, director of perinatology; and perinatologists **Michael Paidas, MD**, and **Adrei Rebarber, MD**.

**Peg Knight, RN**, director of sales and network development at Rancocas Hospital in Willingboro NJ, was selected as one of the 1999 Outstanding Women of Burlington County in the field of health services.

**Cathyann Worek, RN, MA**, was recently named director of managed care contracting and financial clinical services at Capital Health Systems in Trenton.

**Dr. Jeffrey B. Morris**, chief of the department of emergency medicine at Virtua-Memorial Hospital in Burlington County, recently received a plaque and a letter from the Department of Health and Human Services in Washington DC on behalf of the team of health care professionals at Virtua-Memorial who worked to receive and treat 200 Kosovar refugees.

**Alice G. Renick Ettinger**, pediatric nurse practitioner and program coordinator at Saint Peter's University Hospital's Division of Pediatric Hematology-Oncology in New Brunswick, was elected president of the national Association of Pediatric Oncology Nurses.

**Robert Pallay, MD**, from Belle Mead NJ, has been appointed to serve as a member of the American Academy of Family Physicians Commission on Public Health for 2000.

## **HACKENSACK UNIVERSITY MEDICAL CENTER JOINS ORCHID CLINICAL GENETICS NETWORK**

Orchid Biocomputer, Inc., Princeton NJ, and Hackensack University Medical Center and its Institute for Biomedical Research announced that the medical center has joined Orchid's Clinical Genetics Network. Richard Davies, MD, chairman of the department of surgery and professor of surgery at the University of Medicine and Dentistry of New Jersey (UMDNJ)-New Jersey Medical School, has been appointed to oversee and coordinate the effort for the medical center.

The medical center will gather

and provide Orchid with highly secured clinical samples and patient histories. Orchid will analyze these samples at its facility in Princeton to determine the presence and role of single nucleotide polymorphisms (SNPs). Each SNP will be correlated with a disease or disease characteristics to elucidate how the SNP affects the efficacy and side effect profile of specific therapeutics in these individuals. For more information, call (609) 750-2200 or visit Orchid's Web site at [www.orchidbio.com](http://www.orchidbio.com).

## **THIRD EDITION OF PHYSICIAN CD-ROM AVAILABLE**

The third edition of the *Core Curriculum in Primary Care* CD-ROM nine-disk series is now available. It allows primary care physicians to earn up to 36 hours of Category I or Prescribed CME credits. The nine CDs cover gastroenterology, psychiatry, pain and risk management, office otolaryngology, laboratory tests and imaging studies, office surgery and urology, preventive medicine, metabolic diseases, and pulmonary medicine and asthma.

Each is four hours long. Each CD is available for \$49 for individual users and \$99 for libraries and institutions. The entire series is \$349 for individuals and \$699 for libraries and institutions. A biweekly Internet publication, *Primary* (<http://healthstreamuniversity.com/primary>) supports the series with links to additional resources on the Web. For more information, call (800) 845-1579.

## **INTERNET-BASED STUDENT PRODUCTS FOR HUMAN HEALTH AND MEDICAL EDUCATION**

Benjamin/Cummings, an imprint of Pearson Education's Addison Wesley Longman, and [adam.com](http://adam.com), a provider of online medical and health information and publisher of a variety of interactive, multimedia educational materials, have announced an initiative to develop Internet-based student products for medical and human health education.

The first initiative is an interactive, Web-based tool for students studying college-level physiology. The companies are also evaluating courses that might benefit from Web-based study tools such as human anatomy.

The product is expected to launch in the spring of 2000. For more information, call (415) 344-3708 or (415) 402-2331 or visit Web sites [www.adam.com](http://www.adam.com) or [www.awlonline.com/bc](http://www.awlonline.com/bc).



## **THE PAYMENT ERROR PREVENTION PROGRAM**

It has been estimated by the Office of the Inspector General (OIG) that Medicare has made an estimated \$20 billion in incorrect payments annually. These payments were primarily the result of providers billing for incorrectly coded, noncovered, insufficiently documented, or medically unnecessary services. To address this issue and to protect the integrity of the Medicare Trust Fund, the Health Care Financing Administration (HCFA) is directing the Peer Review Organizations (PROs) to implement the Payment Error Prevention Program (PEPP). Under PEPP, a more directed approach will be taken by PROs across the country to specifically address inpatient hospital payment errors under the new contract with HCFA. The Peer Review Organization of New Jersey's (PRONJ's) involvement in this aspect of hospital operations, however, is not new. Under previous HCFA contracts, PRONJ has been conducting chart reviews since 1984.

The assumption is that most payment errors do not involve fraud and are instead caused by the lack of provider education and awareness in relation to the complexities of the payment process. Through PEPP, PRONJ will apply the principles of continuous quality improvement by using data analysis to identify trends and to develop interventions to rectify this situation.

For the first year of PEPP, which began in November 1999, PRONJ will work with hospitals to identify the source of payment errors (both underpayment and overpayment) with regard to unnecessary admissions and miscoded DRG assignments. The program will focus on promoting system changes and developing educational programs that will help prevent future errors. Other areas will be addressed during the balance of the three-year contract.

PRONJ will not be paid a bounty as a result of these efforts and will not be held accountable for or rewarded for any dollars recovered. The purpose of PEPP is not to recover money or assume fraudulent activity but to identify systematic causes of error and then to show providers how to prevent recurrence of those errors and how to put in place systems to ensure that they comply with Medicare billing rules.

PEPP will have very little impact on physicians, because only hospital bills will be examined by PROs. The only involvement physicians may have will be in revising an incorrect diagnosis or supplying information to supplement insufficient documentation necessary for inpatient care, since it would be inappropriate to make decisions about either of these topics without requesting physician input.

For more information, contact PRONJ at (732) 238-5570.

## **RECOMMENDATIONS FOR INSTITUTIONAL REVIEW BOARDS**

The Department of Health and Human Services' Agency for Health Care Policy and Research announced that it is developing recommendations for helping institutional review board and similar bodies protect against the disclosure of personal health information in research that could be used to identify individual patients. The recommendations will help provide guidance to research reviewers as they review research projects using identifiable information and as they implement the department's privacy regulations mandated by the Health Insurance Portability and Accountability Act of 1996. Proposed regulations for this act were announced by President Clinton in October 1999. Under this act, a final rule is to be issued in February 2000 with a two-year implementation period for most covered entities.

The guiding national principles will be based on a study by the Institute on Medicine of the National Academy of Sciences, which is expected to be completed in the summer of 2000.

Institutional review boards (IRBs) are committees formed by universities and other research institutions to review federally funded research projects and research projects funded by other sources at institutions—mostly academic—that voluntarily submit their study applications. These committees possess the authority to approve, disapprove, suspend, or terminate previous approval of such research to protect the rights and welfare of human subjects. An IRB approval means that the research has been reviewed and may be conducted at an institution within the constraints set forth by the board. Not enough is known, however, about how IRBs can adequately protect patients from potential harm resulting from the disclosure of personal health information in patient databases used in studies. Furthermore, the ways in which IRBs review health services research projects may vary. The guiding principles and best practices developed under this initiative should provide a basis for identifying how to protect personal health information wherever, and by whomever, it is used for research.

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Henry S. Kane  
Professional Liability  
Specialist

By insuring the members of your group practice together, on one policy, you enjoy the security of individual limits for each doctor with the economies of scale previously afforded only to Hospitals, HMOs, and Clinics. As Independent Insurance Agents we offer our clients access to ALL the major malpractice insurers operating in New Jersey. We have been successful negotiating group policies without even changing insurers!

Group policies are relatively new, having only come into use over the last three years, savings typically range from 10% to 35%. If your group collectively pays more than \$50,000 a year for its malpractice insurance and has a good claim history call Henry S. Kane today to discuss the options available to you.



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JAYNEE LAVECCHIA HAS BEEN COMMISSIONER OF THE DEPARTMENT OF BANKING AND INSURANCE SINCE AUGUST 1998. WHEN GOVERNOR CHRISTINE TODD WHITMAN APPOINTED HER TO THIS POSITION, SHE HAD BEEN SERVING AS DIRECTOR OF THE NEW JERSEY DIVISION OF LAW FOR FOUR YEARS. BEFORE THAT, COMMISSIONER LAVECCHIA WAS DIRECTOR AND CHIEF ADMINISTRATIVE LAW JUDGE FOR THE OFFICE OF ADMINISTRATIVE LAW, FROM 1989 TO 1994. IN THE PAST, SHE HAD ALSO BEEN DEPUTY CHIEF COUNSEL FOR GOVERNOR THOMAS KEAN.

# Jayne LaVecchia

*Commissioner of the Department  
of Banking and Insurance*

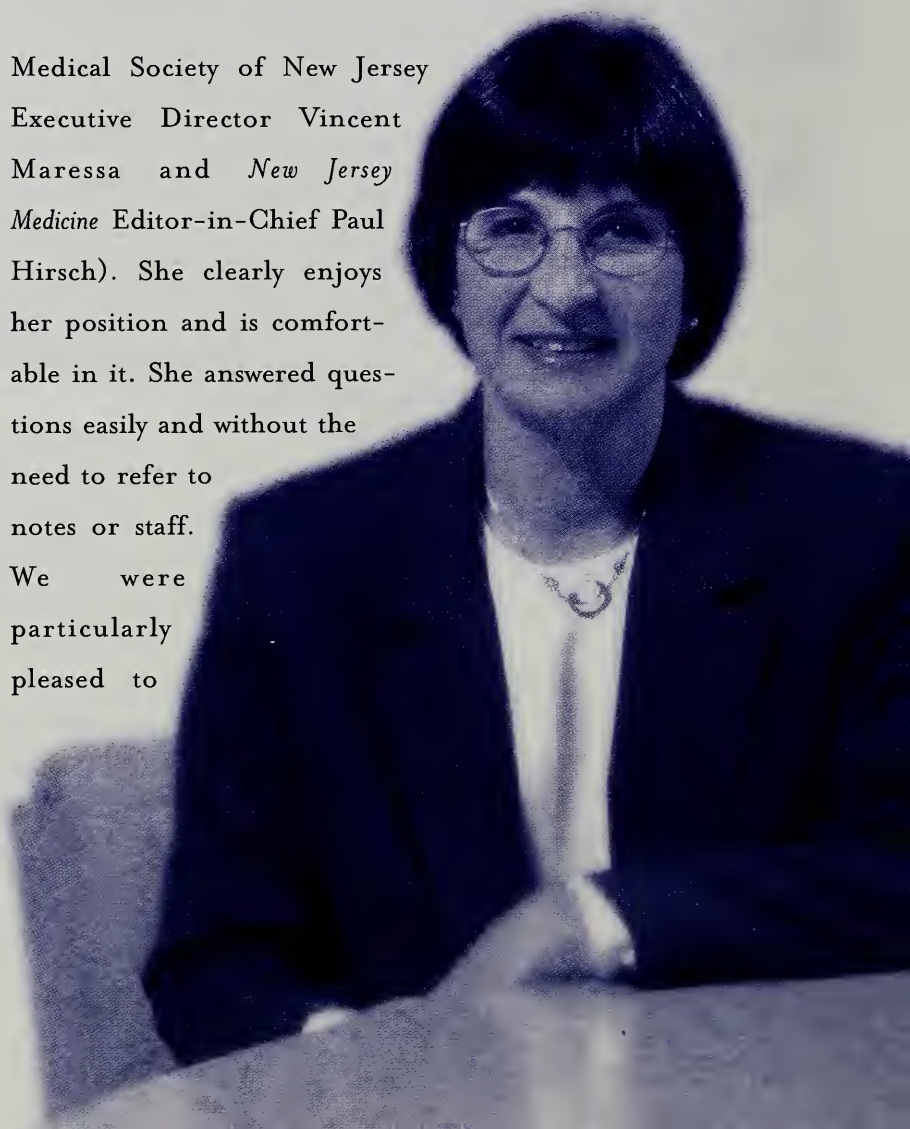
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As commissioner of the Department of Banking and Insurance, Jaynee LaVecchia regulates 1,128 insurance companies in New Jersey. She is also responsible for chartering, licensing, and supervising nearly 6,000 financial, banking, and brokerage entities.

Her regulatory authority over the insurance industry is of key importance to the medical community. Many of the critical issues of health care and reimbursement for health care have come before her department or will do so.

Commissioner LaVecchia was interviewed in her office in Trenton by *New Jersey Medicine* (represented by

Medical Society of New Jersey Executive Director Vincent Maressa and *New Jersey Medicine* Editor-in-Chief Paul Hirsch). She clearly enjoys her position and is comfortable in it. She answered questions easily and without the need to refer to notes or staff. We were particularly pleased to



find that she is truly concerned about the problems faced by providers.

**New Jersey Medicine:** Throughout the summer and fall of 1998, the medical community experienced extreme difficulty with the collapse of the HIP HMO operation. As the newly appointed commissioner, you took some very aggressive and dynamic steps to prevent serious injury to the patients and providers. Could you describe the strategies and actions that you took?

**Commissioner LaVecchia:** The HIP circumstances were presented to me very early on. It was on my second day on the job that I was briefed on the problems that had arisen with regard to HIP and its contractor PHE. That was the third week in August. Over the next few weeks, we went through a series of very intensive private meetings with both HIP and PHE. There was an awful lot of finger-pointing going on between those two companies as to who was responsible for the problem and how extensive the problem in fact was. It led to the department's taking several steps. First, as you now know, I put HIP into administrative supervision, confidentially. Once we began to get our arms around the magnitude of the financial and management problems within HIP and in HIP's interactions with PHE,

I thought it was important for the medical community and for the membership of HIP to know that we were dealing with serious issues, and thus we made the administrative supervision order public. That was an important step for the department; it had not been done before. I thought that disclosure to everyone was a necessary protection for all, as we tried to work through the problems of the company.

Ultimately, as you know, we weren't able to find a viable solution within HIP or a viable partner to come in and resolve all of the debts of the corporation. So we ended up taking a number of steps to make sure that providers—medical professionals and the hospitals—would be paid at 75% of their contracted rate. We put into place transitional steps to ensure quality of care and conti-

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nity of care for the members as they moved to other HMOs. I signed an order mandating that other HMOs had to take the membership in and that they couldn't perform medical underwriting, so that there would be no impact on the members because of medical conditions.

Then, with the agreement of the other HMOs and with the strong assistance of the Medical Society of New Jersey, we made sure that pregnant women and people with chronic or acute conditions could make a transition with their existing medical professionals to another HMO, even though that HMO might not have a contract with that medical professional.

**NJM:** At the present time we are through the rehabilitation period and into the liquidation period. There are some providers that are still owed money related to services rendered during rehabilitation. You have clearly indicated that you expect that those services would be reimbursed at the 75% rate that you just mentioned. Do you still expect to meet those requirements in liquidation?

**Commissioner LaVecchia:** Absolutely. Let me tell you where we are. At this point, we have paid medical professionals, doctors and hospitals, \$42.3 million toward their 75% payment. That represents 80%



of the amount we believe is owed to complete the 75% payment. We have about 20% left to go. As we are going to press, I am releasing another \$6 million in payment to medical professionals. This will bring us over the 90% mark. Shortly thereafter, I expect two additional claims resolutions on behalf of the HIP estate that, when released, should bring us to the 100% mark at or near the end of 1999.

**NJM:** There are prerehabilitation debts owed by HIP. We know that you, along with the Governor's office, have worked very hard to develop a mechanism to address that issue. We do know that it requires legislation, so it goes beyond just the Governor and you deciding that something needs to be done. Could you explain how that issue will be addressed?

**Commissioner LaVecchia:** We have proposed an HMO Insolvency Fund that is similar in nature to a guarantee fund that's used in other insurance settings, structured in such a way to generate sufficient contributions by the remaining HMOs, and with a contribution by the state, to pay what we believe is a reasonable percentage of the total prerehabilitation debt of these two insolvent HMOs—HIP and APPP [American Preferred Provider Plan]. The original version of this bill met with

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some discontent with the legislature, but there have been ongoing discussions as to whether a different structure for collecting funds would be more suitable for the creation of a one-time guarantee fund. The Whitman administration is actively discussing the need for its bill with the legislature and the HMOs right now. The structure last discussed would have generated funds equal to approximately two-thirds of the prerehabilitation debt that we estimate at about \$150 million for HIP and APPP. I would urge the legislature to continue moving in that direction, during the "lame duck" debates, and I hope that it does. [This discussion was held in late

October, just before the election.]

**NJM:** Are there other HMOs in the New Jersey market that are also showing financial instability?

**Commissioner LaVecchia:** Right now, looking at the second-quarter 1999 financial statements, which are the most recent to come into the department, each HMO operating in New Jersey is satisfying its statutory net worth requirements. Based on my conversations with them, at least two will be showing nice increases in their third-quarter financials. I don't see signs of financial instability in any of the companies.

**NJM:** Recently, both the state and federal governments approved Aetna's acquisition of Prudential's health plans. It is somewhat controversial among physicians, and clearly Aetna has acquired a very significant position in the New Jersey market and continues to grow. Do you plan to monitor its behavior and practices, and could you explain the mechanisms that you might use and what the length of time of this closer observation would be?

**Commissioner LaVecchia:** The short answer is yes, we do plan to monitor both the transition of Prudential coming into Aetna, which should take place over a two-year period or less, and to monitor Aetna's performance of the merged business for three years beyond that.

In the order that Commissioner Grant and I signed approving this merger in New Jersey, we put a number of conditions in place that will require information submission and data collection by Aetna and filing requirements with both departments. This will enable us to watch activity with regard to medical professionals, the number of doctors who are signed on, and rate changes with regard to doctors as well as members. There are about a half-dozen paragraphs in the order that were focused exclusively on data demands that we were placing on Aetna and Prudential to give us the information that would be necessary to properly monitor it. We will hire the necessary experts to collect and analyze data to help us monitor New Jersey market share and impact on Aetna's market share position vis-à-vis performance in the marketplace, so that we can quickly and early on see any monopolistic or monopsonistic indexes as a result of this activity.

**NJM:** Those are all excellent concepts and parameters, and we think they will assure the physician community that there will be very close observation of the behavior of the industry generally, and any significant segment of it when necessary, by the state government.

The entire HMO and health insurance industry has been under-

going a fair amount of consolidation. Actually, even the property and casualty industry and all financial institutions have shown the same pattern. Do you envision more or less consolidation in the health insurance market in New Jersey?

**Commissioner LaVecchia:** We have recently gone through a period when there was a fair amount of merger activity. It seems to have slowed down. At the present time, I'm aware of potential merger discussions by a very small company in South Jersey, involving fewer than 7,000 members. If the merger goes through, I don't see it significantly affecting market share, nor am I aware of any other activity that seems likely at this time. We may be going into a period when merger activity will remain lower than it has been in the past.

**NJM:** Self-funded ERISA plans [Employee Retirement Income Security legislation enacted by the

federal government in 1974] do not come under state regulation. Is there any way other than federal legislation to bring those plans under state supervision for patient-protection issues? Are employers who use plans that do not comply with New Jersey law notifying their employees as required by the New Jersey Health Care Quality Act?

**Commissioner LaVecchia:** The Department of Health monitors compliance with the notification law to which you refer. But, I must note that it is something of a toothless requirement. All it requires is notice to employees of mandated benefits that are available if they were in plans regulated by the state, unlike an ERISA plan. We don't control the ERISA plans. About 50% of New Jersey insureds are covered by ERISA plans.

**NJM:** So that federal regulation is needed, if there is to be any real progress.

**Commissioner LaVecchia:** I'm afraid so. Even though the ERISA federal preemption of state law has been softening through recent court decisions, it is still unclear whether any real consumer protections that we would apply in New Jersey to New Jersey-regulated health plans would ultimately be upheld in federal court if we tried to force their compliance

THE WHITMAN  
ADMINISTRATION IS  
ACTIVELY DISCUSSING  
THE NEED FOR ITS BILL  
WITH THE LEGISLATURE  
AND THE HMOs  
RIGHT NOW.



by ERISA health plans. And that's unfortunate.

**NJM:** Doctors feel relatively powerless in negotiating contracts with HMOs. The HMOs have the money and the insured population. Doctors in New Jersey, for the most part, are in relatively small practices. Do you have any advice for physicians as to how they should go about their contract analysis and review? Is there the prospect of some sort of regulatory restraint over an HMO acting in a unilateral or heavy-handed fashion in contract terms?

**Commissioner LaVecchia:** As you know, the New Jersey regulators historically have been reluctant to step into the role of policing the appropriateness of reimbursement rates between providers and HMOs. Typically, we've limited our regulatory activities to issues relating to the financial performance of the HMO, its financial security, its soundness for the provision of benefits to its insureds, and then of course collaterally we worry about HMOs satisfying their obligations to their service contractors, such as the doctors and the hospitals, because this relates to the entity's overall financial solvency. We are interested in seeing HMOs book and pay their liabilities in a timely manner, but we have not, in the past, delved into or taken a

RIGHT NOW, EACH  
HMO OPERATING IN  
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policing role with regard to the remuneration that is negotiated.

As a regulator, I would pause before thinking of moving in that direction. A number of doctors and doctor-groups are joining together to offer service by specialty or across specialties to have greater contracting power. The role that those groups are playing and the change that they are effecting in the balance of negotiations are important. I think they will help to keep an appropriate balance in the negotiation of rates.

**NJM:** So, in effect, the providers should look for consolidation to develop bargaining power.

**Commissioner LaVecchia:** This is a bargaining strategy that medical professionals need to think through carefully, and it may be the best answer for some of them. I remember the early 1980s, when HMOs were first getting a foothold in New Jersey. The independent practice associations were very powerful.

Things have shifted in the opposite direction in the delicate balance of negotiating power. But it may be time for doctors to realize their commonality of interest for purposes of entering into negotiations, and regaining some of the power that may have diminished over time.

**NJM:** The Medical Society of New Jersey and the American Medical Association have been working on recommended changes under federal and state laws that would allow state exemption under the federal antitrust law, so that self-employed physicians could collectively negotiate under state supervision with carriers that control more than 15% of a relevant market. As the state regulator, do you have an opinion on this?

**Commissioner LaVecchia:** It is a relatively new concept. The department has not taken a position on this issue or on the bills that have been introduced. I'm not sure that the concept requires state supervision for that type of negotiation to take place. Groups joining together in a corporate structure for purposes of negotiation—as we discussed earlier—may solve the problem that the proposed bill, in a much more convoluted fashion, attempts to solve. The proposed legislation may draw government into issues that are not conducive to government involvement.

**NJM:** Recent auto insurance reforms have led to the development of treatment protocols and precertification requirements. Could you explain some of the steps that you have taken in the development and implementation of these protocols?

**Commissioner LaVecchia:** The chief tool that we will be using to monitor implementation is the Person Injury Protection (PIP) Technical Advisory Committee, created by an order that I signed. On that committee will be not only representatives of the professional boards but also representatives of medical professional associations that will be involved in the implementation of these protocols. There is a Medical Society member; there is a representative of the physical therapy association; there is a representative of a chiropractic society. There are also public members, as well as representatives from the insurance industry. Although the medical professionals predominate on the advisory committee, I think that the committee is fulfilling its great promise to meaningfully review and assist me in the evaluation of the new protocols. The members seemed heartened by the level of dialogue that we're having with regard to implementation issues, as they become known. We've had a good deal of conversation at

the last two meetings about the precertification forms that have come under discussion and are now in the process of being approved by the department. When we met yesterday, we brought before the group samples of the precertification forms that have been approved, so that the group could see what kind of procedures the department is approving as appropriate for precertification and that we are allowing the insurance companies to now implement. We will bring more plans back before the group at the next meeting.

We also are talking about having the professional organizations give us time on their upcoming confer-

IN THE ORDER THAT  
COMMISSIONER GRANT  
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BOTH DEPARTMENTS.

ence or professional programs to discuss how the protocols are being implemented, the problems we are seeing with decision paths, and the precertification. We believe that more information and education as to how the new PIP systems is to be implemented will help medical professionals understand them appropriately and bring legitimate concerns to us so that we can adjust the rules if necessary.

**NJM:** You do have an appeal mechanism. . .

**Commissioner LaVecchia:** Several layers.

**NJM:** Is it independent of the carriers involved?

**Commissioner LaVecchia:** Yes. The first layer typically involves outside contracted medical review vendors. Insurance companies are not undertaking to bring on whole new staffs within their organizations. They are going to outside groups, such as medical review groups. The review typically involves the following. The treating practitioner would inquire whether or not a course of treatment would be approved. If it is not approved, it could be disapproved only by a medical professional. It could not be disapproved by a nonphysician. There would also be an opportunity to have that decision reconsidered if there is still disagreement with the treating physi-



cian, who is charged with the responsibility of determining the medical necessity of care. There is the opportunity to go to an outside medical review organization (MRO). We have a process in place whereby arbitration is available with the assistance of the MRO. Medical professionals of like specialty will conduct a review of the proposed course of action, conduct an examination if necessary, and make a recommendation to the arbitrator as to the appropriate course of treatment. The arbitrator will have the ability to make a binding decision. We feel we have a process in place that will allow for independent judgment and independent medical review by a like specialist, as to the care that the physician may think is appropriate.

**NJM:** Will the arbitrator have a medical background?

**Commissioner LaVecchia:** The arbitrator will be an attorney. The American Arbitration Association has received the contract to perform the procedure of the arbitration. The review and the examination, as well as the recommendation regarding the course of treatment, will be through the medical review organization and thus by a physician.

**NJM:** Do you have any estimate of the number of cases that will use that mechanism, in the course of a year?

**Commissioner LaVecchia:** I would be foolish to venture an estimate.

IT IS STILL UNCLEAR  
WHETHER ANY REAL  
CONSUMER PROTECTIONS  
[REGARDING ERISA]  
THAT WE WOULD APPLY  
IN NEW JERSEY TO  
NEW JERSEY-REGULATED  
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ULTIMATELY BE UPHOLD  
IN FEDERAL COURT.

But I can tell you this. One of the enhancements that the new PIP system will give us is that arbitration will require a written decision, with explanation, and will be filed with the department. We will make all of them electronically available through our Web site. A body of decisions and precedents will therefore become available. Through this process, we hope to reduce the number of controversies that the system is generating right now.

**NJM:** One of the things we hear most about from our members is the slowness of payments from managed care companies and insurance companies. Would you comment on your department's efforts in the area?

**Commissioner LaVecchia:** We also receive individual complaints from

doctors and hospitals. But the law did not establish the Department of Banking and Insurance as an individual claims ombudsman for each instance of slow pay that is brought to our attention. The law did not intend for us to play that role. But we have a prompt-pay law in New Jersey that needs to be enforced, and the department is charged with recognizing patterns or practices of conduct of companies that demonstrate lack of compliance with this law. The intensity of this problem between the industry and the doctors and hospitals has gotten to a point at which the staff needs to look more comprehensively into it than we have in the past.

The Hospital Advisory Commission is engaging an outside consultant to perform a representative claims audit to better analyze this problem. If further review is necessary, I am prepared to allocate department resources to engage in necessary fact-finding regarding this problem.

**NJM:** We think that's exciting information and look forward to hearing more about it. Commissioner, thank you for your time and for your interest in the problems facing the medical community. The Medical Society looks forward to working with you to continue to seek solutions.

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# DOCTORS KNOW BEST

*Rep. Bob Franks*

In today's world of managed health care, patients are becoming increasingly concerned about who is in charge of making critical decisions about their health care—doctors or insurance companies.

Physicians and their patients should not find themselves at the mercy of insurance companies. For the vast majority of Americans who receive their health insurance coverage through their employers, however, there is little protection from abusive or unfair practices by HMOs.

We need to put doctors and patients back in control of health care decisions. Americans need a guarantee that they will receive the best medical care available when they need it the most.

Last October, I joined with my colleagues on both sides of the polit-

ical aisle in passing historic legislation—the Norwood-Dingell Patients' Bill of Rights—that is aimed at putting doctors, not insurance companies, in control of health care decisions.

In an effort to empower patients and doctors, the Norwood-Dingell

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bill passed by the House of Representatives would:

- *Allow a patient to sue an HMO.* Patients (or their families) would have the right to sue when an insurer makes a decision that causes injury or wrongful death. If a patient is irresponsibly denied appropriate care by a plan and the patient suffers negative health consequences, the HMO could be held liable for its actions.
- *Guarantee access to emergency-room care.* In an emergency, every second counts. No one should be forced to drive past the nearest hospital emergency room because that facility is not a member of the provider network. Under the bill, HMOs would be required to cover emergency care expenses even if



the hospital is not a member of their health care network.

- *Guarantee the right to appeal a denial of coverage.* Patients and their physicians must have control over the quality of their health care. The legislation requires all HMOs to institute an internal review process that ensures that coverage disputes are resolved quickly and fairly—before they have a negative impact on health consequences. Physicians—not the insurance companies—would be in charge of deciding what treatments and procedures will be covered.
- *Guarantee the right to an independent appeal for denial of coverage.* If a patient does not agree with the findings of an internal appeal, the legislation provides for a timely, independent review of the case by doctors outside the health care network. The appeals would be heard by doctors who specialize in treating the medical condition in dispute. All appeals must be resolved quickly—before a patient's health is further compromised.

- *Guarantee access to specialists.* The bill would provide women with direct access to an OB/GYN specialist. Children would be able to see a pediatrician without prior approval or being required to first visit their primary physician.
- *Abolish all gag rules.* Patients should not be kept in the dark about treatment options. They need to know all the options available so they can choose the best course of treatment. Under the bill, physicians would be able to present all of the treatment options available—not just those that are covered by the health plan.

PHYSICIANS—NOT  
INSURANCE COMPANY  
BUREAUCRATS—WOULD  
BE IN CHARGE OF  
DECIDING WHAT  
TREATMENTS AND  
PROCEDURES WILL BE  
COVERED.

The Norwood-Dingell bill prescribes strong medicine to combat the abusive practices of HMOs. Unfortunately, the Senate passed a weaker version of HMO reform.

I am hopeful that the Conference Committee—which will be considering the two different versions of HMO reform early this year—will recognize the need to provide doctors and patients with the strongest, most comprehensive protection available. When it comes to ensuring quality health care for Americans, compromise is not an acceptable option.

Bob Franks is serving his fourth term representing the Seventh Congressional District of New Jersey, comprising parts of Essex, Middlesex, Somerset, and Union Counties. Franks serves on the House Budget Committee and the House Transportation and Infrastructure Committee. In January 1999 he was named chairman of the new Subcommittee on Economic Development, Public Buildings, Hazardous Materials and Pipeline Transportation and vice-chairman of the new Subcommittee on Ground Transportation. He is also co-chairman of the Congressional Missing and Exploited Children's Caucus and the Northeast Midwest Congressional Coalition. He and his wife, Fran, and daughter, Kelly, live in Berkeley Heights.

# POLYPHARMACY

## REDUCING ADVERSE EVENTS AMONG THE ELDERLY IN NJ



THIS IS THE SECOND OF A TWO-PART SERIES THAT FOCUSES ON REDUCING POLYPHARMACY AND ADVERSE DRUG EVENTS IN THE COMMUNITY-DWELLING ELDERLY. PART 2 FOCUSES ON THE MEDICAL EXCEPTION PROCESS (MEP), EXPLAINS INFORMATION FLOW RELEVANT TO THE PHYSICIAN'S PRACTICE, AND PROVIDES CLINICAL EXAMPLES ILLUSTRATING THE POTENTIAL OF COMPUTER TECHNOLOGY IN IMPROVING OUTCOMES OF CARE. A COMBINED APPROACH, WHICH EMPLOYS COMPUTER-BASED TECHNOLOGY, VALUES PHYSICIAN JUDGMENT, AND STRESSES PATIENT AND PROVIDER EDUCATION, IS DESCRIBED.



*George T. Hare, MD, FACP; Susan C. Reinhard, RN, PhD; Jane H. Brick, MSN, RN, NPC; Carl Tepper, RPh, FASCP, CCP, Martin T. Zanna, MD, MPH*

Although the implementation of a medical exception process system will result in the denial of some claims, its interactive design provides physicians with an opportunity to provide concurrent medical justification to override a denial. On the basis of experiences in Pennsylvania (where this system is already in place), it is predicted that, on average, physi-

cians will receive about two inquiries per month from the fiscal agent. The type of information the physician will be asked to provide to substantiate a medical exception includes supplementary diagnostic information, anticipated length of therapy, and results of previous medication trials.

Explaining the medical rationale for a prescription by the clinician is

a core component of the medical exception process. Furthermore, in instances that do not involve severe drug interactions, the MEP provides reasonable time frames for obtaining information from the physician to support an exception and permits short-term (30-day) approvals. These time frames provide an opportunity to resolve a given clinical situation and to minimize



inconveniences to the physician, patient, and pharmacist.

A MEP contractor selected by the state will play a major role in facilitating this process, particularly in ensuring that appropriate prescriber-pharmacist-contractor interaction occurs to support a medical exception process. As recommended by the State Board of Medical Examiners (BME), this contractor will include the services of physicians licensed in New Jersey. Figure 1 outlines the MEP operation. Action and intervention points for physicians, pharmacists, and for fiscal agents or MEP contractors are indicated.

As can be seen from Figure 1, the majority of steps in the MEP flow chart relate to the MEP contractor's intervention with the pharmacy. Only a limited number of action points in the system require direct physician involvement. Physicians should be aware of the different types of clinical edits (hard and soft) that may affect their patients' prescriptions as well as the actions physicians must take for an intervention and the time frames involved.

### CLINICAL EDITS

Clinical edits endorsed by the Drug Utilization Review Board (DURB) are composed of both soft and hard edits. Soft edits result in warnings; the pharmacist may dispense a short course of therapy with the MEP contractor's approval at the

POS. Therefore, the physician's intervention is not required in the initial dispensing of medication corresponding to a soft-edit claim. Continued therapy, however, requires appropriate physician action. Hard edits trigger claim denials, resulting in a situation in which the patient is unable to receive any medication until the physician intervenes. Examples of the interactive dynamics involving the MEP contractor-attending physician-pharmacist are given in Table 1.

Previously, the clinical edits used by state pharmacy benefit programs have been activated only as a warning to the pharmacist. The Pharmaceutical Assistance to the Aged and Disabled (PAAD) program along with the New Jersey Medicaid program, the General Assistance program, and the AIDS Drug Distribution Program (ADDP) will shortly deny payment for some clinical edits (based on DURB criteria) classified as hard, as is further shown by the examples provided in Table 2.

### PROVIDER EDUCATION AND FEEDBACK

Physicians are encouraged to collaborate with the Department of Health and Senior Services (DHSS) in the implementation phase of this decision-support tool by carefully reviewing detailed operational instructions as published in future DHSS and Department of Human Services (DHS) newsletters. A Web site will be maintained by the medical exception contractor, with

access to provider newsletters, contact numbers, and other valuable clinical information. In addition, physicians will be given periodic feedback through ongoing reports designed to evaluate the effect of prospective drug utilization review/point-of-sale (PDUR/ POS) systems on clinical outcomes.

### CLINICAL STRATEGIES AND CONSUMER-FOCUSED EDUCATIONAL APPROACHES TO ADDRESS POLYPHARMACY

Polypharmacy is usually the result of several factors:

- Multiple chronic diseases.<sup>1</sup>
- Lack of patient feedback to the primary care clinician.
- Patient expectations that medications will be ordered by physicians for relief of particular symptoms while continuing other medications.<sup>2</sup>
- Drug-drug disease.
- Failure of the physician to review medication regimen on a regular basis.<sup>3</sup>
- Unclear frequent changes in medication regimen.
- Use of multiple providers and pharmacies by patient.<sup>4</sup>
- Multiple refills and hoarding of medications.

Knowledge of these factors is useful in identifying clinical strategies as well as in designing consumer-focused educational approaches. Several practical guidelines to consider in helping to reduce polypharmacy are discussed in the following sections.

MEP Medical Exception Process  
 POS Point of Sale  
 DURB Drug Utilization Review Board  
 MERF Medical Exemption Request Form  
 Clinical edits (hard and soft) are defined in Table 1.

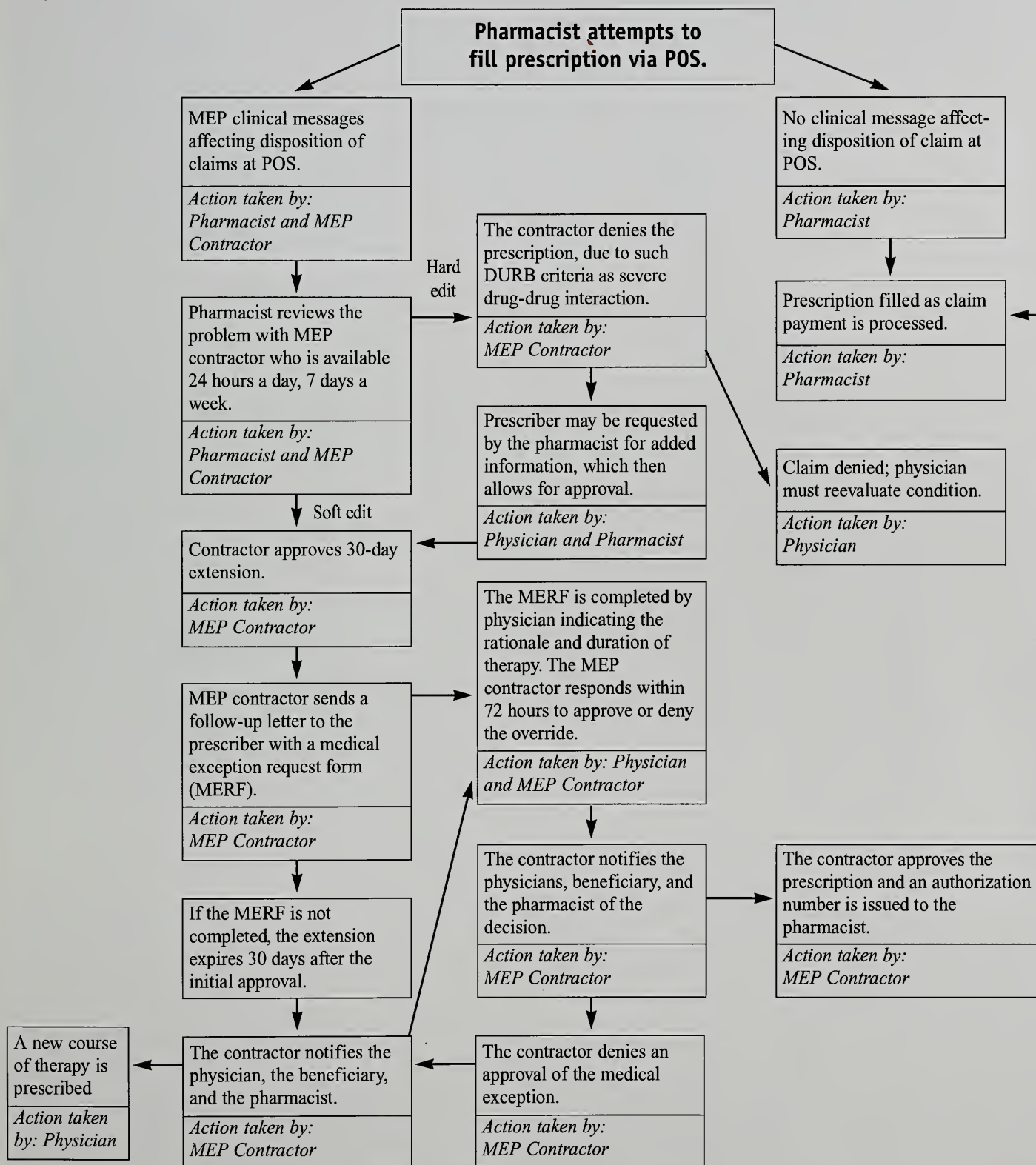


Figure 1. Medical Exception Process Decision Tree



|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Definition                                                                                                                                       | Explanation                                                                                | Example                                                                                                                                                                                                                                                                                                                                                        | Physician Action                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hard Edit Denial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | An edit that results in a denial of claim payment, because the claim fails to meet MEP criteria.                                                 | A severe drug-drug interaction.                                                            | Concurrent dosing of an antihistamine (astemizole) and antifungal agent (itraconazole) is identified at POS. The pharmacist receives a clinical message along with a hard-edit denial code. The patient receives NO medication without the physician ordering a therapeutic substitution to prevent a potential adverse drug event (e.g., cardiac arrhythmia). | Physician must intervene at POS to resolve the edit conflict. In patients receiving either of these conflicting medications, at least one week should lapse before initiating therapy with the other agent. If an antihistamine is medically needed with itraconazole, the physician makes an appropriate therapeutic substitution, which will not result in a potential adverse drug event. <sup>a</sup> The MEP contractor's licensed clinical staff are available to provide consultation to the attending physician. |
| Soft Edit Warning Message                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | An initial warning that does not result in claim denial. The claim fails to meet some MEP criteria. The pharmacist must call the MEP contractor. | Duration of therapy, duplicative drugs in the same therapeutic class, or excessive dosages | Doses of ranitidine of more than 150mg after a 90-day initial treatment period of an acute dose is identified at POS. The pharmacist receives a clinical message along with a soft-edit code. The patient receives a supply of medication (up to 30 days) and a medical exception request form is sent to the physician.                                       | Physician must either adjust the dose or respond to the medical exception request form. Maintenance doses of ranitidine should be initiated after initial treatment of an active duodenal ulcer. Reduction to 150mg ranitidine is appropriate for maintenance therapy. <sup>b, c</sup>                                                                                                                                                                                                                                   |
| <p>a. <i>References Clinical Pharmacology</i>. 1998. Gold Standard Multimedia Inc. Hansten, P.D., and Horn, J.R. 1997. <i>Hansten and Horn's Drug Interactions Analysis and Management</i>. Vancouver WA: Applied Therapeutics. pp. 76-77.</p> <p>b. Berarardi, R.R.; Byrns, P.J.; Collins, T.; Freston, J.W.; Howells, R.R.; Schultz, N.J. <i>Drug Use Review for H<sub>2</sub>-Receptor Antagonists: Criteria and Guidelines for Use</i>. 1993. Professional Programs Philadelphia College of Pharmacy and Science. pp 9-10.</p> <p>c. Duration of therapy editing is under review by DURB.</p> |                                                                                                                                                  |                                                                                            |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

Table 1. Consequences of application of medical exception: clinical edit criteria and corresponding physician action(s)

| CONFLICTS BETWEEN DURB CRITERIA AND PRESCRIPTION INFORMATION ENTERED INTO SYSTEM AT POS                                                                                                                                                                           | EDIT TYPE |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| Acute dosing of H-2 blockers for up to 90 days; after 90 days converts to a hard edit.                                                                                                                                                                            | Soft      |
| Concurrent dosing of an H-2 blocker with a proton pump inhibitor.                                                                                                                                                                                                 | Soft      |
| Duplicate therapy of H-2 blockers, HMG Co-A reductase inhibitors, NSAIDs, ACE inhibitors beta-blockers, calcium channel blockers, miscellaneous gastrointestinal agents.                                                                                          | Soft      |
| Excessive dosage of an H-2 blocker, HMG Co-A reductase inhibitor, antipsychotic agent, NSAID, anxiolytic, sedative-hypnotic, ACE inhibitors, cardiac glycosides, beta-blockers, calcium channel blockers, miscellaneous gastrointestinal agents, antidepressants. | Soft      |
| Severe drug interactions.                                                                                                                                                                                                                                         | Hard      |

Table 2. Disposition of potential conflicts by edit type\*

\* Contingent on DURB approval

*Obtaining a detailed medication history.* A detailed medication history may be the clinician's most valuable tool in helping to reduce polypharmacy. Beginning with the initial visit, encourage your patients to brown-bag their medications for each office visit. This step can set the tone for each office visit by having an informed patient. Ask the patient to bring all medications, including prescription and over-the-counter medications, herbs, vitamins, and other nonpharmacological treatments to the initial visit and to follow-up visits. Review what the patient is taking and how the patient is using the prescriptions and other preparations. Remember that the

more medications a patient takes, the more confusing it may become. Patients do not always view over-the-counter medications as having a potential for harm, so it is important to inquire whether they are using these medications.<sup>5</sup> Remember that it is not uncommon for patients to borrow or share medications with a neighbor or friend for economic reasons.<sup>6</sup> Finally, inquire if patients are taking any other preparations or medications that they have not brought to the office. While reviewing medications, look for duplication of generic and brand-name medications. Check for use of multiple pharmacies or multiple physicians. Always ask

whether the patient has been seen by another physician and, if so, what medication was ordered or given and for what problem. Inquire about previous drug reactions in the past. Ask whether the patient has a prescription plan such as PAAD.

*Not treating every symptom.* Have a frank discussion with the patient and explain the risks and benefits of medication. Patients may visit physicians with the expectation of medication for each symptom.

*Avoiding drug-drug disease.* Multiple prescriptions associated with multiple chronic diseases may contribute to a greater incidence of a drug reaction or drug interaction, increased risk of worsening the patient's condition, and increased risk of noncompliance. Drug disease interactions may also compound the problem. Make certain that new medications do not affect the therapeutic actions of medication already being taken.

*Simplifying the medication regimen.* Prescribe medications that require dosing only once or twice a day, and prescribe only long enough to treat the problem. Make a practice of consistently writing prescriptions using the same drug name (trade or generic).<sup>7</sup> The inconsistent use of generic or trade names may contribute to the patient taking double doses of the same medication.

*Reviewing the medication profile with the problem list at each visit.* Discontinue drugs that are no longer necessary,



and avoid the use of large quantities of PRN medications. Maintain a drug profile, which can be readily referenced to improve ease of documentation.

*Limiting the number of refills.* Remind office staff to check the date of last follow-up if patient calls for refills, and follow your established policy for refills and office visits.

*Recommending the use of one pharmacy.* Provide an explanation of why this practice is important.

*Discouraging multiple providers.* Remind patients to inform you if they are seeing another provider and request that the physician notify you of any medications prescribed to avoid duplication or drug interactions. Know whether your consultant is prescribing medications. Some primary-care physicians request consultants to allow them to prescribe the medications.<sup>8</sup>

*Reminding patients to discard unused and outdated medications.* Patients often save prescribed medications and over-the-counter medications for use at a later date. This provides another risk of polypharmacy through self-prescribed medication. Patients should be reminded to check with the physician before using any medications (prescribed, over-the-counter, herbs, etc.) they may have saved from a previous illness.

*Educating patients about the drug therapy.* Inform the patient about the purpose of the medication, dosage frequency, and route of administration. Instruct the patient about side

effects and specific instructions for this medication, indicating when the patient should call the office if specific signs and symptoms arise. Explain to the patient to take the medication until the prescription is finished. Patients may not refill a prescription if the physician is not clear as to how long they are supposed to take the medication. The nurse in your office may effectively provide some of the medication education along with clear, large-print instructions. Remind patients to always obtain additional information from the pharmacist, which will serve as reinforcement to your instructions. Communication is the key.

## CONCLUSION

As a critical player in the implementation of a statewide approach to reduce polypharmacy, the physician's role in the MEP is to augment the computer-based system by bringing medical judgment into the process. This expands the potential of preventing adverse drug events and improving patient care. Physicians are encouraged to incorporate a variety of clinical strategies into their practice to avoid the pitfalls of polypharmacy. In summary, a comprehensive combined approach to reduce polypharmacy has been taken by the state and includes the following: (1) computer-based prospective drug utilization review (PDUR); (2) a medical exception process (MEP); (3) patient education; and (4) provider education strategies.

Susan Reinhard is deputy commissioner, Martin Zanna is medical consultant, and Carl Tepper is regional pharmaceutical consultant with the Department of Health and Senior Services; George Hare is medical director at Camden County Health Services Center, Blackwood NJ; and Jane Brick is geriatric nurse practitioner and assistant professor of clinical medicine at Cooper Health System, University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School at Camden. The authors wish to thank Kathy Mason, Director, PAAD Program, for her input and advice.

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# HEALTH CARE ISSUES FOR SPECIFIC POPULATIONS OF EMPLOYEES

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FORMULATION OF A MEDICAL TREATMENT PLAN BY A PHYSICIAN CAN BE INFLUENCED BY AN INDIVIDUAL'S CURRENT AND PAST MEDICAL CONDITIONS, GENDER, AND SOCIOECONOMIC, RACIAL, AND GENETIC BACKGROUND. THIS APPLIES EQUALLY TO TREATING WORK-RELATED INJURIES AND ILLNESSES. EXPERIENCED WORKERS' COMPENSATION CLINICIANS KNOW THAT TREATMENT GUIDELINES DEVELOPED TO TREAT ONE GROUP OF WORKERS MAY NOT BE EFFECTIVE FOR OTHER POPULATIONS OF EMPLOYEES.

*James D. Lomax, MD*

**T**he casual reader may receive the impression that there are not great differences among populations of workers because federal and state agencies often report only cumulative results in their labor statistics. The other challenge in thinking about this topic is that there are many ways to characterize any working population. Age, gender, and socioeconomic backgrounds are highlighted in this article, along with the major occupational differences that distinguish these groups of employees. Certainly all treatments must be individualized, but if these broader issues are not consid-

ered, the clinical outcome may be less than ideal.

## **GLOBAL ECONOMIC CHANGES AFFECTING ALL EMPLOYEES**

In the past decade, there have been many changes in all workplaces, both globally and in the US. Today, despite a strong economy and record-low unemployment, there are more than 44.3 million Americans who are not adequately insured; this represents about half of the low-waged workers in the US (*New York Times*). Many employers have downsized, with more overtime or increased production quotas expected from each employee. Other important trends are the

increase of women and young people participating in the workforce, with a proportional decline of adult male workers, and the overall aging of the current working population. In addition, the number and types of employment arrangements are changing, with more part-time, casual, seasonal, and self-employed persons. In the US, there is a decline in the average job tenure for all industries, creating persistent personnel turnover in many companies.

All these factors have profound effects on job satisfaction, types of available positions for various groups of the working population,



and exposure of large numbers of working people who are not physically adapted to their job demands. These factors have a negative impact on the various groups of employees discussed in the following sections.

## MINORITY WORKERS

The US has a diverse population. For the year 2000, the US Census Bureau estimates that there will be 275 million persons living in the US, consisting of 71.6% whites, 12.8% African-Americans; 11.3% Latinos; 6.9% native Americans, Eskimos, Aleuts; and 4.4% Asians and Pacific Islanders. Many of the minority groups receive lower incomes, live in inferior housing, have less education, and generally have a worse health status. All of these factors have strong statistical relationships to increased risks of work-related injuries and illnesses.

There are a number of historical accounts that describe situations in which minority workers were exposed to a much higher risk of workplace hazards than their white counterparts. Because of this exposure to adverse environmental factors, many African-American and Latino workers in the past also sustained significantly more frequent, serious, and fatal occupational injuries and illnesses. This had much to do with the fact that often the only available jobs for these

workers were in construction, mining, and agriculture.<sup>1,2</sup>

Today, minority workers make up the largest percentage of workers in certain occupations. For example, more than 40% of seasonal farm workers are from Central and South America.<sup>3</sup> The "sweatshop" work environment is often the first place of employment for new immigrants. Companies that employ a large number of workers who may not be legal residents often have a history of violating existing safety, health, and labor laws.

Occupational medicine articles describe a number of environmental hazards that either cause or can exacerbate underlying health condi-

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tions. Because a higher incidence of various chronic diseases occurs in some minority populations, doctors need to think of the impact of both the person's home and work environment. Some examples:

- Lung cancers—Certain types of cancers, particularly lung, are associated with a higher frequency of smoking in various populations, plus exposure to known workplace carcinogens such as silica and asbestos.
- Asthma—There are now hundreds of environmental substances, many found in the workplace, that are associated with causing or exacerbating adult-onset asthma.
- Hypertension—This common disease can lead to end-stage organ damage, especially the central nervous system and kidneys. Known workplace exposure to nephrotoxic substances, such as metal fumes and hydrocarbons, and potent neurotoxins, such as lead and organic solvents, can accelerate this damage.
- Diabetes—There is increased susceptibility to developing peripheral neuropathy and renal disease in a diabetic patient who is exposed to many of the organic solvents and pesticides found in the work environment.

- Infectious diseases—Many minority workers are employed in the health care industry. Tuberculosis is more prevalent in the communities where many of these workers live, and this additional occupational exposure may increase the risk of developing active diseases.
- Genetic susceptibility—There are nationalities and races that have higher frequencies of genetic conditions, such as G6PD deficiency and abnormal cytochrome 450 systems. This may place some minority workers at higher risk for developing a health crisis or suffering an increased incidence of drug side effects with prescribed and OTC medications when their metabolic systems are already challenged by workplace exposures to various chemicals.
- Alcohol abuse and addiction—This is a universal health problem for all groups of workers, but there is a higher incidence of morbidity and mortality related to alcohol use in the workplace when the compromised employee is in a high-risk environment for physical injuries, as is the case for many minority workers.

## FEMALE WORKING POPULATIONS

A growing percentage of the US workforce is female. Until recently,

**POSITIONS COMMONLY FILLED BY WOMEN ARE IN THE HEALTH AND CAREGIVING PROFESSIONS AND IN CLERICAL AND ASSEMBLY-LINE POSITIONS. THESE TYPES OF POSITIONS PLACE THE WOMAN AT RISK FOR A NUMBER OF FREQUENTLY ENCOUNTERED WORK-RELATED INJURIES.**

working women have been underrepresented in labor statistics because many positions are part-time or casual, which many working mothers prefer. There continue to be male-dominated professions that have discriminated against hiring females, regardless of physical capabilities. For these reasons, women have had a narrower range of industries and professions in which to find employment. This places women at much higher risks than their male counterparts for specific kinds of injuries and illnesses related to such professions.

Positions commonly filled by women are in the health and caregiving professions and in clerical

and assembly-line positions. These types of positions place women at risk for a number of work-related injuries. Some examples:

- Musculoskeletal injuries—Nurses, home care professionals, physical therapists, and other types of caregivers all experience a higher incidence of soft-tissue injuries related to caring for patients who cannot walk or move independently. In addition, carpal tunnel syndrome and other upper-extremity repetitive motion disorders are commonly found in female workers.
- Infectious-disease exposure—Health and child-care employees, teachers, social workers, and other caregivers are exposed to a wide range of potential infectious diseases that can include all of the hepatitis viruses, varicella, tuberculosis, HIV, measles, mumps, rubella, and cytomegalovirus.
- Cancer risks—Some female workers have higher exposure to known carcinogens often found in hospitals and industrial settings that may increase their chances of developing cancer. Some examples of this are X rays, ethylene oxide, ethyl acrylate, and dichloromethane.
- Reproductive risks—This is a growing area of research in occupational medicine because it



appears that the overall fertility of men and women in the US may be decreasing. In women, this concern relates to spontaneous abortion, miscarriage, genetic defects in offspring, low-birth weights, and premature ovarian atrophy. Exposure to alkylating agents, lead, mercury, and polychlorinated biphenyls (PCBs) are known to cause premature ovarian atrophy. There is controversy about exposure to video display terminals and spontaneous abortions.

- **Stress-related conditions—**Female employees often have multiple roles in both the home and workplace. Child-rearing responsibilities, in addition to work demands, place many females in a chronic stress situation. An increasing number of employers are attempting to accommodate the primary caregiver of a child or older parent by allowing flexible work hours or flexible-place positions (i.e., allowing the employee to do work at home).

## WORKING TEENAGERS

Teenage workers constitute an important portion of the American workforce. It is estimated that at any time there are 200,000 14 to 17 year olds employed in the US. This population of workers, however,

represents a high-risk group for injuries. In 1997, there were more than 64,000 injuries in this age group that required some form of emergency care. OSHA records more than 70 deaths annually in this group.

Federal and state laws prohibit certain types of employment for persons under 18 years of age. Certain high-risk jobs—such as those that entail driving, positions in mines and sawmills, and potential exposure to radiation—are prohibited for persons younger than 18. Fourteen and fifteen year olds may not work as bakers or cook except at a serving counter, work on ladders or scaffolds, or be on a construction site.<sup>4</sup>

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These limitations restrict jobs for teenagers to sales, kitchen work, construction (for those older than 16), unregulated agricultural work, and child-care and nursing-assistant positions. These types of jobs expose the young worker to injuries from heavy lifting, cuts and burns, repetitive soft-tissue sprains, and physical harm when the teenager becomes a victim of workplace violence. There is also a potential for developing long-term health problems from exposures to chemicals, infectious agents, and asbestos.

The physician should take the same type of careful employment history for the teenager as for the adult patient. Because many of these positions are summer, after-school, or evening jobs, the family, doctor, and teenager may overlook this as an important part of the medical history when performing routine exams.

Most injuries in this age group are strains and sprains incurred because of inexperience or inadequate strength. Also commonly encountered are lacerations, contusions, burns, and fractures. Low-back pain is very rare in this age group and, when found, the doctor should consider an underlying nonoccupational health condition. Agricultural injuries are common, and unfortunately, a significant number of serious injuries and deaths occur in teenagers employed in this area.

## OLDER WORKERS

There is no official definition for the term *older worker*, but the average age of employees in the US is increasing because of the aging of the baby-boom generation, which makes up an important part of the US working population. This aging of the American workforce has concerned many employers and legislators because of the impacts on the total health care costs for both occupational and nonwork-related conditions. This issue will become even more important in the years ahead, because life expectancy has significantly increased and many people anticipate continuing to work because of better overall health and the deferral of full social security benefits from 65 to 67.

Labor statistics from 1995 show that the highest percentage of workers were males and females 55 through 64 years of age. The effects of normal aging on this age group and even older employees include:

- Physical capabilities decline, even for a person who exercises regularly and is in good health.
- The ability to quickly learn new skills and process information declines with aging. An older worker has the same equal recall of familiar information as a younger person and is usually more accurate in performing learned routine tasks. Because of

## MOST INJURIES AMONG YOUNG WORKERS ARE STRAINS AND SPRAINS INCURRED BECAUSE OF INEXPERIENCE OR INADEQUATE STRENGTH, AS WELL AS LACERATIONS, CONTUSIONS, BURNS, AND FRACTURES.

the significant growth of service-oriented industries in the US, however, the ability to quickly process new information is becoming an essential part of more and more jobs. How this will affect our aging workforce needs to be determined.

- The impact of chronic illnesses on job performance can be significant for the older person. The presence of musculoskeletal, cardiovascular, respiratory, and mental disorders negatively affects the overall functioning of the older employee and increases the risk of injury.
- Permanent disabilities resulting from workplace injuries are higher in workers aged 55 years and older. This significantly affects the insurance costs for that employer and has a negative impact on employee productivity.

## CONCLUSION

There are many other groups of employees that require special consideration but are beyond the scope of this article. The doctor needs to be sensitive to the issue that a person presenting with an injury is often part of a group of workers that require special consideration when formulating a treatment plan. An employee may be part of more than one specialized group, with the treatment plan requiring even more individualized attention, rather than following a one-size-fits-all approach to treatment.

*James D. Lomax is medical director of MasterCare Companies, Inc., in Clark NJ.*

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# DISCLOSING GENETIC INFORMATION TO FAMILY MEMBERS

## Do Old Paradigms Fit the New Medicine?

LAUNCHED IN 1990, THE HUMAN GENOME PROJECT (HGP), AN AMBITIOUS, INTERNATIONAL, FEDERALLY FUNDED PROJECT TO MAP AND SEQUENCE ALL HUMAN GENES, HAS RAPIDLY EXPANDED OUR GENETIC KNOWLEDGE. NOT ONLY DOES THE HGP PROMISE TO ARM PHYSICIANS WITH IMPRESSIVE DIAGNOSTIC TOOLS, ITS ULTIMATE TARGET IS RADICAL IMPROVEMENT IN THERAPEUTIC AND PREVENTIVE INTERVENTIONS IN A NEW ERA OF GENETIC MEDICINE. AT THE SAME TIME, HOWEVER, THE GENETIC REVOLUTION POSES MOMENTOUS ETHICAL, LEGAL, AND SOCIAL QUESTIONS. DURING THE PAST DECADE, A SUBSTANTIAL—AND UNRESOLVED—DISCOURSE HAS EMERGED ABOUT SUCH MATTERS AS GENETIC PRIVACY, GENETIC DISCRIMINATION, RESEARCH WITH STORED TISSUE SAMPLES, OWNERSHIP OF GENETIC MATERIAL AND INFORMATION, GENE PATENTING, AND THE GENOMIC CHALLENGE TO TIME-HONORED CONCEPTS OF HEALTH AND DISEASE.

*Robert S. Olick, JD, PhD*

The beginning of the 1990s marked the law's first attempts to come to grips with a less-discussed issue involving genes at the bedside. For the first time, two people sought to vindicate their right to know their parents' genetic secrets. In New Jersey, Donna Safer, 36 years old and recently married, was diagnosed with a cancerous blockage of the colon and multiple polyposis, for which she underwent a total abdominal colectomy with ileorectal anastomosis. Additional metastatic cancer was detected, leading to removal

of her left ovary. Approximately eight months later, following a period of chemotherapy, Ms. Safer obtained her father's medical records and discovered that his death 26 years earlier was from the same condition for which she had just been treated. Knowing now that multiple polyposis was an inheritable condition and that early detection would have afforded an opportunity for early intervention and perhaps avoidance of the most serious consequences of her progressive disease, she and her husband sued the estate of her father's physician,

Dr. George T. Pack, for negligent failure to warn her of her genetic risk. At about the same time in Florida, Heidi Pate made a similar discovery. She was diagnosed with medullary thyroid carcinoma, the same condition for which her mother had been treated three years earlier. Pate and her husband sued her mother's physician and the hospital and clinic where he practiced for failing to warn Heidi's mother that her children were at risk for this genetically inherited condition. They claimed that if her mother had been given this information she



would have shared it with her daughter and that, if apprised of the risk, Heidi would have taken preventive actions that, more likely than not, would have cured her condition.

In the first ruling of its kind (*Safer v. Pack*), issued in the spring of 1996, the New Jersey appellate division held that "the duty to warn of avertible risk from genetic causes . . . [is] owed not only to the patient. . . but . . . also 'extend[s] beyond the interests of a patient to members of the immediate family of the patient who may be adversely affected by a breach of that duty.'"<sup>1</sup> A year earlier the Florida Supreme Court (*Pate v. Threlkel*) also vindicated the daughter's claim, but on a different basis. Holding that in some circumstances physicians have an affirmative duty to protect third parties from harm, the ruling stopped short of imposing a duty to notify families directly, concluding instead that the physician's duty "will be satisfied by warning the patient."<sup>2</sup> Under *Pate*, the physician who advises the patient of familial risks and the importance of disclosure may then say, "Now it's up to you." *Safer* supports the proposition that the physician's duty to directly warn family members about genetic risks may occasionally take precedence over patient confidentiality.

When, if ever, is it justifiable to breach the traditional duty of confidentiality to notify family members of genetic risks? Physicians and other health care professionals have for decades been called on to test the

limits of confidentiality in a variety of contexts, including those involving potentially violent psychiatric patients, contagious and infectious diseases, gunshot wounds, and child, dependent-adult, or spousal abuse. As a general canon, it is so well-established—in both ethics and law—that confidentiality must *sometimes* yield to the protection of others from harm that the proposition seems almost commonplace. The three-judge panel in *Safer* concludes that "there is no essential difference between the type of genetic threat at issue here and the menace of infection, contagion, or a threat of physical harm."<sup>3</sup> In this view, genetic testing presents a familiar quandary that fits within existing paradigms. A more probing analysis suggests, however, that factual differences may hold more complex ethical and policy implications, limiting the utility of these analogies. Physician disclosure is often predicated on a

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psychiatric patient's intent to cause serious harm to another or perhaps reckless disregard for another's safety; so too with notification of sexual or needle-sharing partners of the HIV-positive patient. Harm is avertible if the patient's threatened actions can be stopped. But patients do not put others at risk for genetic conditions—relatives either have the genetic predisposition or they do not. (A counterexample arises when genetic information, such as a family history of Huntington's disease, is relevant to reproductive choice; but unaffected spouses have a weaker claim to the right to know than the patient's potentially affected children or siblings.) With rare exception—for example, malignant hypothermia, an autosomal dominant disorder that causes a fatal reaction to anesthesia—asymptomatic genetic conditions do not hold the prospect of imminent harm. And unlike contagious and infectious diseases, the zone of risk for "disease genes" is restricted to biological relations within families, a seriously weak link in the public health analogy. Moreover, while the course of infectious disease exhibits relative uniformity and predictability, genetic conditions, most of which are multifactorial, are marked by substantial variability, burdening genetic prediction with considerable uncertainty.

Writing for the NJ court, Judge Kestin characterizes the physician's obligation as a "narrow" duty to families. This conclusion embraces

a second premise—that genes are inherently a matter of familial concern, giving families a special claim to genetic information. But contrary to the conclusion that this premise supports limited duties to others of the sort embraced by the psychiatric and public-health models, the idea hints at a series of complex and profound questions suggesting far more expansive obligations to families. Should we view genetic information as, in a sense, family property—jointly owned? One hypothesis of such a view is that children are entitled to a copy of their parents' genetic report card, at least when the condition is (very? somewhat?) serious and medicine has (something? a lot?) to offer, even if not a cure. To go a step further, we might begin to see families as "patients," as beneficiaries of the physician's oath to promote the patient's good. Transforming the ground of the discussion in this way entails a paradigm shift, in which care becomes patient-family centered, inviting direct conflicts among the best interests of patients, and striking at the heart of ancient bonds of trust between physicians and patients. Does genetic exceptionalism of this sort advise extending the patient's zone of privacy to include potentially affected relatives; or does the uniquely personal, private, and familial nature of genetic information (as well as the social risks of discrimination) warrant special privacy protections, more stringent than those for sharing other health information?

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The recently enacted New Jersey Genetic Privacy Act (NJGPA), signed into law in 1996, supplants *Safer* as the primary source of legal guidance for physicians but does not put the matter to rest. In stark contrast to the judiciary, the legislature embraces the latter position, rejecting the lessons of the old paradigms in favor of a patient's near-absolute right to control access to genetic information. Hailed as an exemplary commitment to individual privacy (most state genomic laws aspire to proscribing insurance and employment discrimination and say little about privacy), the NJGPA enjoins that neither the identity of a person on whom a genetic test has been performed nor identifiable personal genetic information may be disclosed without permission from the tested individual or that person's legal representative.<sup>4</sup> Of the IO enumerated exceptions, only the statutory permission to assist medical diagnosis of a blood relative when the patient has died—a situation that existed during a portion of the *Safer* saga—is directed to the bed-

side. (Pertinent language appears to allow disclosure if it can be done without revealing the identity of the patient, but this is a challenging and often unrealistic task.<sup>5</sup>)

This clarion call to safeguard genetic privacy is a welcome development, but its stringency should also be received cautiously. Several respected organizations—including a subcommittee of the American Society of Human Genetics, the Institute of Medicine's Committee on Assessing Genetic Risks (IOM), and the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research—have concluded that health care professionals ought to be "legally privileged" to disclose genetic information to a patient's relatives in appropriate circumstances.<sup>6-8</sup> This judgment embraces the general canon noted earlier and calls for a case-by-case determination of whether the benefits and harms of disclosure outweigh the benefits and harms of protecting confidentiality. One's view of the *Safer* case may well depend on whether she suffered from familial adenomatous polyposis, an autosomal dominant form of colon cancer, and whether careful screening and periodic removal of polyps were then the standard of care. (Both are suggested but left uncertain in the court's opinion.) The extremely high likelihood of gene expression at a relatively early age, together with the fact that this is a treatable disease, make a strong argument for disclosure. A compelling case for



disclosure, noted by the IOM, is another autosomal dominant disorder, malignant hypothermia. When a simple and prompt warning before surgery of near-certain allergic reaction to anesthesia can literally save a life, who would insist that privacy remain paramount? Under the NJGPA, if the patient says no, conscientious physicians trying to protect children facing surgery from the hidden peril of malignant hypothermia, advise relatives with colon cancer to seek early medical attention, or warn an airline that its international pilot has the gene for sudden cardiac arrest may well find themselves confronting another dilemma—it's ethical, but is it legal?

With the inexorable advance of the HGP (announcements of a 90% complete map of the human genome may come as early as this spring) a growing role for genetics in primary health care is equally inevitable. So too are the expanding interests of families in acquiring—and acting on—insights into their genetic profile. Without relying on old models, a new model for the new medicine must take its lessons from what has come before. The direction advocated by the American Society of Human Genetics and others finds an analog in state laws governing human immunodeficiency virus, where most states (not New Jersey) have crafted a legal permission to warn sexual or needle-sharing partners of HIV-positive patients under certain circumstances, affording immunity from legal liability when the statutorily prescribed process is

followed. The model is instructive not because genetic risk is a matter of public health, but because it is an example of the law's ability to carve out room for the exercise of sound medical-ethical judgment and resist the temptation to impose absolute rules. As we embark on this new era in medicine, this foundation holds the promise of flexibility in the face of rapid advances in molecular biology, of sensitivity to the variability of genetic risk, and of attentiveness to

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the familial bond of the human genome.

Robert Olick is associate professor, program in biomedical ethics and medical humanities, University of Iowa College of Medicine, Iowa City. He served as executive director of the New Jersey Bioethics Commission from 1989 through 1992.

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MANAGERS MUST ENSURE THAT FINANCIAL AND HUMAN RESOURCES ARE USED EFFICIENTLY AND EFFECTIVELY IN THE ACCOMPLISHMENT OF AN ORGANIZATION'S OBJECTIVES. THIS INVOLVES ESTABLISHING PLANS AND PERFORMANCE STANDARDS AND CORRECTING DEVIATIONS FROM THOSE PLANS AND STANDARDS.

*Miriam Cohen*

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All practices should use three types of budgets: operating, capital expense, and current budgets. Each serves a different and essential purpose. An operating budget is the

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## BUDGETING AS A STRATEGIC PROCESS

Budgeting is a continual process. Forecasting needs, deciding on organization goals and objectives, and selecting performance indicators are accomplished at the begin-



ning of the budget cycle. This requires delineating the goals for the practice and identifying the specific strategies and tasks necessary to achieve those goals. Then, it is necessary to assess the individual costs and benefits of each task and strategy. The next step is to consider the operational and financial effect of the budget on the practice. The practice manager must create a workable budget format. The required regular monitoring of the cash flow is easier if the budget format is comfortable for the user. Performance measures include an accounting process where the specific system determines when revenues and expenses are recognized and reported in financial statements. Revenue consists of patient collections, rent, interest payments, grants, and any other sources of income. Expenditures are the actual cash disbursements for goods and services. Expenses are the costs of goods and services presumed to benefit the current accounting period, regardless of the timing of the expenditure.

There are two types of accounting systems, cash and accrual. For the cash-based system most often used by physician practices, revenues and expenditures are recorded only when cash changes hands or bills are

paid. It is a simple system and familiar since it operates like a check-book. The risk is that it allows the user to ignore unpaid bills and remain unaware of what resources have already been used. Therefore, it is possible to spend money more than once. In the accrual method, revenues are recorded when earned and expenditures are immediately noted as a liability. When the actual money was received or the expenditure occurred is not important. It is necessary, however, that the practice manager remain cognizant of when revenue is received or expenditures are made. Failure to do so may result in an overexpenditure of resources.

Regular audits are a major contributor to fiscal health. Auditing is

**AN INDEPENDENT AUDIT  
PROVIDES THE PRACTICE  
MANAGER WITH THE  
DOCUMENTATION TO  
COMPARE AND ANALYZE  
THE ACTUAL  
PERFORMANCE OF THE  
ORGANIZATION AGAINST  
THE STANDARDS THAT WERE  
ESTABLISHED IN THE  
INITIAL BUDGETING  
PROCESS.**

the accounting process in which financial records are examined for accuracy. Corrections of accounting errors can then be made. An analysis of performance standards occurs when the results of the internal accounting/audit process are made available to parties interested in the financial condition of the entity. An independent audit provides the practice manager with the documentation to compare and analyze the actual performance of the organization against the standards that were established in the initial budgeting process. This provides the basis for identifying problem areas, investigating solutions, and beginning corrective action. When the operating performance of the organization is evaluated, a revision of the program budget may be necessary to correct any deviations.

All practices can benefit from accurate and timely information. Understanding and using the budget will provide practice managers with that information. The key to good management is good management control. The key to good management control is a well-planned budget that becomes a part of the practice's daily operations.

*Miriam Cohen is a consultant with the MIIX Healthcare Group, a consulting and management firm located in Lawrenceville NJ.*

# WHAT'S RIGHT TO DO?

## NEW JERSEY MALPRACTICE CASES REFLECT CLINICAL QUANDARIES

THERE'S NO FORMULA FOR MAKING THE RIGHT CLINICAL DECISION IN THE FACE OF COMPETING FACTORS OF PERSONAL VALUES, COST-QUALITY TRADE-OFFS, INSUFFICIENT INFORMATION, AND SOCIAL ENVIRONMENTS THAT LIE BEYOND THE CLINICIAN'S REACH.

*Neil E. Weisfeld*

Selected court cases reported in the *New Jersey Jury Verdict Review & Analysis* in 1999 suggest the level of complexity of clinical decision-making at century's end.

### A PHYSICIAN'S ETHICS

A 29-year-old woman with a history of two abortions presented to an obstetrician-gynecologist with another pregnancy. The physician advised the patient that if she wanted another abortion, she would have to go elsewhere. But the patient and her husband wanted this baby.

An alpha-fetoprotein test at 17 weeks produced results that were

somewhat elevated but still within the normal range. (An expert subsequently testified that the expected risk of Down's syndrome for the patient was one in 787, that the normal range ended at one in 270, and that the test revealed an actual risk of one in 404.)

A belief that she might be bearing twins led the patient to obtain an ultrasound examination at 21-22 weeks on her own initiative. The test disclosed a mucal thickening of the neck that is a hallmark of Down's syndrome. On the advice of a radiologist, the patient then obtained a level-2 ultrasound, which con-

firmed the finding. The patient telephoned the obstetrician.

According to the patient's subsequent account, the physician advised her that they would discuss the test results at her next scheduled visit five days later, on April 12. At that time, she said, she and her husband requested an amniocentesis, and the physician advised that it was too late in the pregnancy for an amniocentesis but that there was no basis for concern.

According to the physician's subsequent account, he did not personally see the patient on April 12 but did speak with her by phone. He



recounted that he told her that she could undergo amniocentesis, but that she declined.

The pregnancy went to term. Down's syndrome was diagnosed shortly after birth. The parents brought a "wrongful birth" action against the obstetrician. They contended that she or any reasonably prudent person in the same situation would have obtained an abortion when confronted with the prospect of giving birth to a baby with Down's syndrome.

The parents further sought punitive damages from the obstetrician, on the grounds that his actions were willful, wanton, and malicious. They maintained that his strongly held antiabortion views led him to discourage testing that could lead to an abortion.

An expert obstetrician-gynecologist testified for the plaintiff that the defendant physician should have counseled the patient about the results of the alpha-fetoprotein test and advised an ultrasound, should have strongly counseled them about the ultrasound findings, and should then have suggested amniocentesis, which in fact was still a viable option.

The defense denied that such counseling and advice were required. Indeed, ultrasound could prove harmful to the child, the defense contended.

At deposition the defendant stated that early on he identified the patient as the sort of individual who constituted a "social risk" and might undertake litigation against him. He allowed that he sometimes asked such patients to sign a waiver if they declined a test that he recommended. He conceded that he did not ask the patient to sign such a form when the amniocentesis was decided against.

Two nurses who worked in the defendant's office testified that the patient and her husband visited the office on April 12 in an agitated state. The nurses related that the parents did see the defendant at that

time and appeared reassured after the conversation.

The baby did not appear in court. An expert pediatric neurologist testified for the plaintiff that the child ultimately will require institutionalization and probably would test out at an IQ of about 50. A cost-analysis expert testified for the plaintiff that the expected daily cost of maintaining the child would run between \$84 and \$134. The parents described their emotional distress but did not make a claim for psychotherapy.

The judge instructed the jury that punitive damages would require proof by clear and convincing evidence of willful, wanton, and malicious conduct. The jury found that the defendant was negligent and that his negligence caused the injuries to the baby and his parents. The jurors awarded \$1.5 million to the child, \$250,000 to the mother for emotional distress, and \$100,000 to the father for emotional distress. The jury did not award punitive damages.

#### A PATIENT'S DETERMINATION

A woman with a history of alcoholism lost her job at about the same time that she and her lover, with whom she owned a home, ended their relationship after 14 years. The

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HIS STRONGLY HELD  
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HIM TO DISCOURAGE TESTING  
THAT COULD LEAD TO  
AN ABORTION.

home was sold, and the woman delivered the proceeds of the sale to her sister, along with instructions to be followed in the event of her death.

Over a period that lasted seven weeks, the woman recorded a series of audiotapes. On the tapes she repeatedly expressed a desire to kill herself. She also frequently expressed deep anger toward her mother.

After the seven weeks, following a medication overdose ascribed to a suicide attempt, the patient was admitted to a hospital and placed under the care of a psychiatrist. The psychiatrist prescribed the antidepressant Zoloft. He was told about the audiotapes but made no effort to obtain them.

The patient complained to a patient advocate in the hospital that she wanted to be discharged. After the patient arranged for postdischarge care with an alcoholism counselor, the psychiatrist discharged the patient to a motel. The hospital stay had lasted eight days.

The next day the sister visited the patient. They did not see each other again. The patient missed her appointment with the alcoholism counselor. The psychiatrist did not follow up with the patient. One month after the discharge, the 46-

AN EXPERT PSYCHIATRIST  
TESTIFIED FOR THE  
PLAINTIFF THAT THE  
PATIENT SHOULD HAVE  
BEEN HOSPITALIZED  
FOR AT LEAST  
EIGHT WEEKS.

year-old patient fit a plastic bag over her head and suffocated to death.

The sister and their mother brought a malpractice action against the psychiatrist. They claimed damages for the loss of guidance and advice that the patient would have given them if she had lived longer. They also claimed damages for the patient's pain and suffering at death.

An expert psychiatrist testified for the plaintiff that the patient should have been hospitalized for at least eight weeks. The expert commented that several weeks would be required to reach a therapeutic dosage for the antidepressant. He added that the lack of a home for the patient exacerbated the possibility of suicide.

The defense contended that, in view of the patient's insistence on ending her hospital stay, an order for an involuntary commitment would have been necessary. A com-

mitment would have required overt signs of suicidal intent. The one-month lapse before the suicide took place demonstrated the absence of any such overt signs, argued the defense.

Commentators in court noted that the audiotapes were a double-edged sword. The tapes suggested that the psychiatrist should have endeavored to keep the patient in the hospital. But they also demonstrated the patient's determination to take her life. The defense further observed that the tapes proved that the patient was unlikely to furnish much advice and support to her mother, although the plaintiff countered that effective psychotherapy would have resolved the patient's problems with her mother.

The jury found that the defendant was negligent. But the jury additionally found that his negligence was not a proximate cause of the patient's suicide. The court entered the judgment for the defense.

## A DRUG'S EFFECTS

A man in his 40s with a history of alcoholism sought care from a family physician for multiple aches and pains and anxiety. The physician ruled out physical causes and prescribed Xanax.

When the prescribed supply of the medication was exhausted, the patient attempted and failed to



reach the physician by phone. The patient then visited an emergency department and obtained an additional supply of the same drug.

Later that day the patient had a single-vehicle accident that caused bilateral femur fractures. His blood alcohol content was found to be .12, exceeding the legal limit. The patient sued the family physician for malpractice, on the grounds that Xanax was contraindicated for an alcoholic patient.

The plaintiff's expert physician stated that Xanax would aggravate the effects of alcohol. The expert also declared that the medication would loosen the patient's inhibitions against drinking.

THE PLAINTIFF'S EXPERT  
PHYSICIAN STATED THAT  
XANAX WOULD  
AGGRAVATE THE EFFECTS  
OF ALCOHOL. THE  
EXPERT ALSO DECLARED  
THAT THE MEDICATION  
WOULD LOOSEN THE  
PATIENT'S INHIBITIONS  
AGAINST DRINKING.

The defendant physician related that the patient had told him that the alcohol abuse had stopped. Moreover, said the defendant, antianxiety medication was necessary to prevent a relapse of drinking. I would not have refilled the prescription if the patient had reached me that day, added the physician, who asserted that the decision to drink and drive, and not medical treatment, had caused the accident.

The jury found for the defendant.

#### WHAT THE EXPERTS SAY

The risk-management newsletter *Loss Minimizer* has summarized the opinions of physician members of malpractice carriers' claims review committees about the causes of malpractice.

In obstetrics cases, say the experts, the main causes include poor management of prenatal care, improper selection of candidates for vaginal births after cesarean sections, and inappropriate management of gestational diabetes.

Following managed care dictates instead of clinical practice guidelines is another indicator of trouble ahead, in the view of the committee members. But, perhaps most ardently, the experts complained about physicians' lack of skills and knowledge in observing principles of data interpretation, logical foundations of the diagnostic process, and

IF YOU THINK THAT  
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the management of clinical uncertainty.

Another issue of *Loss Minimizer* focuses on the inevitability of error in medical practice. The newsletter notes the distinction between "slips," or errors of action, and "mistakes," or errors in planning. Most research into human error has been undertaken in the field of aviation, observes writer Scott Berglund. Medicine therefore will be using aviation studies as a guide.

The newsletter laments the tendency in medicine to see error as a failure of character as well as ability. Mr. Berglund comments that the punitive nature of corrective measures, such as malpractice litigation, discourages effective analysis.

If you think that you're more likely to be blamed than praised for your decisions, it's hard to face a clinical problem objectively. ■

## E V E N T

## D A T E

## L O C A T I O N

## J a n u a r y 2 0 0 0

|                                                             |                     |                                                                                         |
|-------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------|
| <b>NJ State Society of Anesthesiologists</b>                | January 18, 2000    | Forsgate Country Club, Jamesburg, (609) 275-1911                                        |
| <b>Nephrology Society Meeting</b>                           | January 18, 2000    | UMDNJ-Robert Wood Johnson Medical School, New Brunswick, AMNJ, (609) 275-1911           |
| <b>Diagnosis and Treatment of Type II Diabetes Mellitus</b> | January 19, 2000    | St. Mary's Hospital, Passaic, (609) 275-1911                                            |
| <b>Breast Surgery Symposium</b>                             | January 21, 2000    | Arlington, Virginia, (703) 820-7400                                                     |
| <b>Partnerships for Health in the New Millennium</b>        | January 24-28, 2000 | Dept. of Health and Human Services, Omni-Shoreham Hotel, Washington, DC, (202) 205-1842 |
| <b>Protocol for Out-of-Hospital DNR</b>                     | January 26, 2000    | St. Mary's Hospital, Passaic, (609) 275-1911                                            |

## F e b r u a r y

|                                                      |                      |                                                                               |
|------------------------------------------------------|----------------------|-------------------------------------------------------------------------------|
| <b>Neurological Emergencies</b>                      | February 2, 2000     | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Prenatal Diagnostic Genetic Menu</b>              | February 9, 2000     | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Nephrology Society Meeting</b>                    | February 15, 2000    | UMDNJ-Robert Wood Johnson Medical School, New Brunswick, AMNJ, (609) 275-1911 |
| <b>Multiple Chemical Sensitivity in Primary Care</b> | February 16, 2000    | St. Mary's Hospital, Passaic, (609) 275-1911                                  |
| <b>Tuberculosis Control</b>                          | February 23, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Trauma Care for the New Millennium</b>            | February 24-26, 2000 | Atlantic City Convention Center, (609) 441-8023                               |

## M a r c h

|                                                       |                |                                                    |
|-------------------------------------------------------|----------------|----------------------------------------------------|
| <b>Clinical Cancer Research</b>                       | March 1, 2000  | The Manor, West Orange, AMNJ, (609) 275-1911       |
| <b>Sleep Apnea Syndrome</b>                           | March 1, 2000  | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911 |
| <b>Treatment of Chronic Bronchitis</b>                | March 1, 2000  | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911 |
| <b>Lumbar Disc Disease</b>                            | March 8, 2000  | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911 |
| <b>Review of Physical Medicine and Rehabilitation</b> | March 10, 2000 | Sheraton Tara, Parsippany, AMNJ, (609) 275-1911    |



# CALENDAR

## EVENT

## DATE

## LOCATION

### March

|                                       |                |                                                                               |
|---------------------------------------|----------------|-------------------------------------------------------------------------------|
| Juvenile Onset Diabetes               | March 15, 2000 | St. Mary's Hospital, Passaic, (609) 275-1911                                  |
| Imaging of Bowel Obstruction          | March 16, 2000 | Cooper Health System, Camden, AMNJ, (609) 275-1911                            |
| Nephrology Society Meeting            | March 21, 2000 | UMDNJ-Robert Wood Johnson Medical School, New Brunswick, AMNJ, (609) 275-1911 |
| Post-Polio Syndrome                   | March 22, 2000 | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| NJ State Society of Anesthesiologists | March 24, 2000 | Trump Plaza Hotel & Casino, Atlantic City, (609) 275-1911                     |
| Travel-Related Illness                | March 29, 2000 | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| Vascular Society of New Jersey        | March 29, 2000 | Morristown Memorial Hospital, AMNJ, (609) 275-1911                            |

### April

|                                       |                |                                                                               |
|---------------------------------------|----------------|-------------------------------------------------------------------------------|
| Medical Problems in the Elderly       | April 5, 2000  | St. Mary's Hospital, Passaic, (609) 275-1911                                  |
| NJ Orthopaedic Society Annual Meeting | April 8, 2000  | Caesar Park Penha, Subtra, Portugal, AMNJ, (609) 275-1911                     |
| Hepatitis                             | April 12, 2000 | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| Nephrology Society Meeting            | April 18, 2000 | UMDNJ-Robert Wood Johnson Medical School, New Brunswick, AMNJ, (609) 275-1911 |
| Peripheral Vascular Disease           | April 19, 2000 | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| Polymyalgia Rheumatica                | April 26, 2000 | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |

### May

|                                               |               |                                                      |
|-----------------------------------------------|---------------|------------------------------------------------------|
| First Annual New Jersey Physicians Conference | May 4-7, 2000 | Atlantic City Convention Center, MSNJ (609) 896-1766 |
| AMNJ Annual Awards Dinner                     | May 24, 2000  | Chanticleer, Short Hills, AMNJ, (609) 275-1911       |

### June

|                                                    |               |                                                    |
|----------------------------------------------------|---------------|----------------------------------------------------|
| Meningitis                                         | June 7, 2000  | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911 |
| Rheumatoid Arthritis: A New Look at an Old Disease | June 14, 2000 | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911 |

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May 12-14, June 16-18, 2000

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*Bernard Robins, MD*

**I**t was 1933. Pop was out of the hospital. Changed, but alive. Paraplegic from a spinal cord tumor and six weeks of radiation. Hair suddenly white. Angry, humiliated, pushing his wheelchair.

The day was sunny and hot. The sky bright. The colors intense. Green, blue. I escaped to the outside. Bouncing a ball against the stoop, I felt freedom, control, pleasure, joy.

Down the street came a peddler with his pushcart. Dirty, disheveled, shuffling in his Old World shoes; a gray-bearded reminder of what we had been. The produce he was hawking looked little picked over—it was the Depression.

Noontime, and the old man, bent low with fatigue and thirst, stopped opposite me, resting on the curbstone. After a moment or two of bowed head, while I continued my glorious game, he took from the cart a glass bottle filled with water and a sandwich from a paper bag. Placing the bottle in the gutter by the curb he started to chew his food.

My disdain pushed me to ever-greater feats (of ball bouncing) until this ball, in a great leap, took itself across the street and with seemingly preordained accuracy struck the bottle.

Shards flew, water splattered. The old man grabbed at a glass fragment and blood, bright red, burst from a finger. With a dirty rag he bound it up, and wearily, appearing hungrier and thirstier than ever, he once again hauled the pushcart down the block. Mutterings of anger spewed forth and I received the gaze I shall never forget.

The sky grew suddenly gray—joy and remorse were ever after commingled.

Forty-three years of practice—can I ever expunge the guilt? Can I sufficiently bind up all the wounds? Can I be a healer without the deep knowledge of being the source of the pain?

That is the question I always ask Pop—but he was gone long before I even knew there was a question.



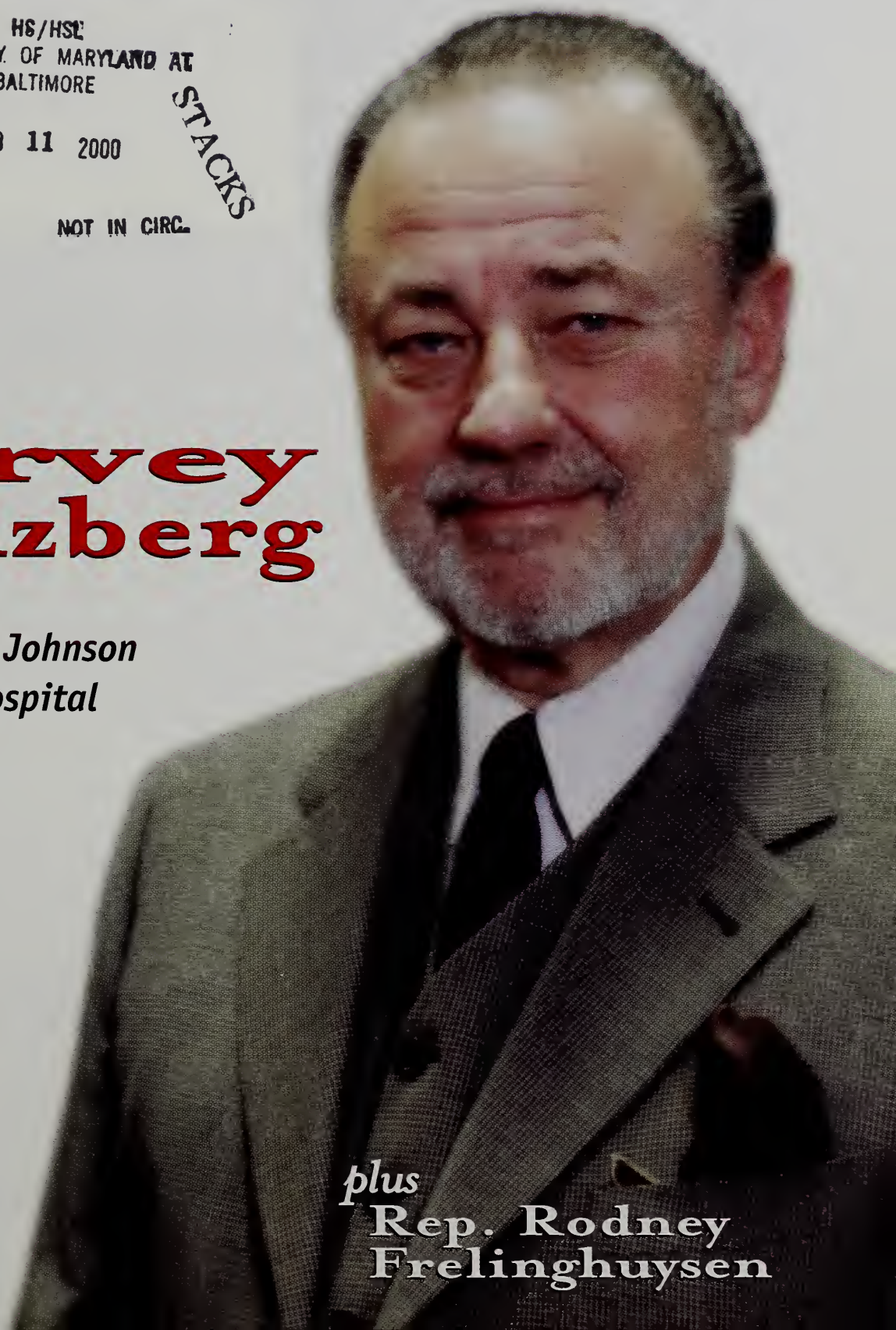
# NEW JERSEY MEDICINE

HEALTH CARE IN THE GARDEN STATE

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## Health care costs: Election year focal point?

As health care moves up on the national political agenda—usually ranking second only to education as a major concern of voters—New Jersey political leaders may give more attention to issues of expansion of health insurance, regulation of managed care, and tobacco control.

Increases in health insurance costs are again vexing employers. Overall premium costs rose 5% last year, reports the Center for Studying Health System Change. Researchers for the Health Care Financing Administration put the figure at 8.2%. Anecdotal reports of higher increases abound.

New Jersey's predicament disturbs. In a state-by-state ranking compiled for the Agency for Health Care Policy & Research, just published in *Health Affairs*, we show the second-highest average premium, for both individuals and families.

**Cost Drivers.** Drug costs are blamed for much of the rise. Private insurers' drug costs have doubled in five

years. In general, health care costs rise as a result of new technologies. Today's health care is very different from the health care of the 1950s, when costs began to spiral.

In the flurry of concern over drug costs, many hospital cost drivers may be overlooked. About three-fifths of the variation in health care costs across employers is attributable to inpatient costs, conclude researchers Matthew Eichner, Mark McClellan, and David Wise, in a study funded by the National Institute on Aging and summarized in *Medicine & Health*.

The typical response to pressures on hospitals is to merge. But in a study published in *Healthcare Business* and summarized in the *Healthcare Leadership Review*, Joanne Todd of McKinsey & Co. found that three-fourths of CEOs of merged hospitals conceded that mergers had not produced the intended results. Reasons for failed expectations included culture clashes between hospital staffs and lack of adherence to a business plan.

**Managed Care Aspects.** It's unclear whether employers and government agencies will again look to managed care to rescue them from ever-increasing health care costs. Critics of managed care are acquiring new arguments.

The Health System Change center reports that many primary care physicians find themselves expected to provide a broader scope

**P**artly because the health care system is so vast, with \$1.1 trillion worth of complexities, reform is elusive. *Medicine & Health Perspectives* cites the failure of Medicare reform as its top news story for 1999. Stuart Altman, PhD, of Brandeis University was dubbed *M&H* Health Person of the Year, in part because he used his pivotal vote on the Medicare Commission to resist reform proposals that he thought were insufficiently prepared.

of care than they are comfortable with. Physicians in capitation or gate-keeping arrangements were especially likely to exhibit this concern. The Center's results were published in the *New England Journal of Medicine* and widely reported in the news media.

Further, a study team led by economist Kathryn A. Phillips of



the University of California-San Francisco reports in *Health Affairs* that "there is only limited evidence to support the common assertion that managed care plans provide more preventive services than non-managed care plans do." In the team's metaanalysis, three-fifths of studies found no difference in disease prevention rates between managed care and nonmanaged care patients.

Analysts for the Wall Street firm of Warburg Dillon Read defend managed care in another *Health Affairs* piece but allow that the industry "blundered" by applying aggressive cost control measures to all patients rather than just the chronically ill, who account for 70% to 80% of total costs. The analysts also acknowledge the "public relations ineptitude" of the managed care folk.

**Medical Angle.** On the physician side, a newly released AMA compendium presents additional cause for concern in New Jersey. The Garden State ranks eighth in physician-to-population ratio. The AMA found that in 1998 there were 314 civilian New Jerseyans for every nonfederal physician. The preponderance of international medical graduates contributes to our state's high ratio.

The steady rise in the supply of physicians may create as many problems for physicians as managed care. When costs continually rise in an industry far larger than education and national defense combined, cost controls should be expected.

The still-expanding physician supply means that expenditures for physician services, now held in check, are distributed over more and more physicians.

Why is cost control certain? Count state officials among those sympathetic to at least some cost control efforts in health care. The National Governors' Association reported on January 4 that health care costs now consume one-fourth of state government spending, according to *Medicine & Health*.

Nationwide, health care consumed 13.5% of the gross domestic product in 1998, according to the Health Care Financing Administration's figures.

**Board Matters.** New Jersey's Board of Medical Examiners is exploring proposals to mandate continuing medical education, require three years of postgraduate training before licensure, and cre-

ate a personalized medical education alternative to disciplinary action. Medical Society of New Jersey members are encouraged to follow these issues—and contribute to their development—through the MSNJ Web site, [www.msnj.org](http://www.msnj.org).

In a display of scholarship rare even among Board of Medical Examiners presidents, the New Jersey board's new head contributes to the *Seton Hall Law Review* an article replete with 233 footnotes. Gregory J. Rokosz, DO, JD, determines that the state should not require medical malpractice insurers to cover acts of sexual abuse of patients.

Dr. Rokosz observes that people usually cannot insure against their own intentional acts of wrongdoing. He also notes that such coverage would raise malpractice costs and would pit the insurers against victims of abuse.

**Think Again.** We've always favored premium subsidies to obtain health insurance for more people. But a microsimulation study by Jonathan Gruber and Larry Levitt now questions that approach, especially as "a solution in and of itself." It costs a lot to insure each new person.



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## **The New Jersey Medicine Interview**

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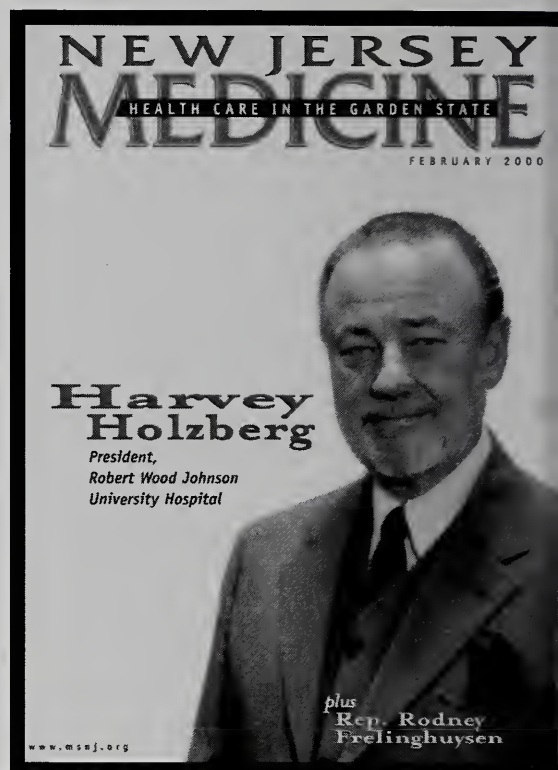
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## INSURANCE COVERAGE FOR INVESTIGATIONAL CANCER TREATMENT

Insurance companies have recently indicated that they would provide payment for investigational cancer treatment. This is a welcome and important decision.

In New Jersey, Gov. Christine Todd Whitman has announced that insurers will cover treatment of cancer patients in federally sanctioned clinical studies. Our program in this state will be the most meaningful in the country. It will unite the state government, patient groups, and physicians in an effort to reach out to cancer patients and inform them that they can

participate in research programs that will be covered by their insurance plans. Incredibly, it appears that there will be little or no cost to the program; insurers have been forced to pay for experimental treatment so often that it is actually a part of their current rates.

We are pleased to see New Jersey as a leader in this area. It should decrease the frustration that these patients and their families often feel in seeking treatment and should also advance cancer research.

**Paul J. Hirsch, MD**

## WILL DOCTORS MAKE THE DECISIONS AGAIN?

We were pleased to note in a recent issue that a major insurer, United Health Group, had announced that it would return decision-making regarding patient care to the doctors in its plan. Now, United has indicated that it would keep some restrictions in place, especially the need for precertification for certain imaging studies and some prescription drugs. It has simultaneously indicated that these requirements would be dropped over the next 12 months, as its own agreements with subcontractors expire.

We are disappointed at the new time frame for the plan but continue to believe that the eventual deter-

minant will be the marketplace itself and how physicians and patients respond to this initiative. United had found that its own efforts at precertification for many procedures and treatments were not cost effective and that it eventually approved 99% of physician decisions.

Insurance companies—and others—will not cease their efforts to control the cost of medical care, nor should they. The previously announced program by the United Health Group, however, seemed to make good business sense and good medical sense. We hope that United and others will give it a chance.

**Paul J. Hirsch, MD**



## SUCCESS FOR AN ACADEMIC MEDICAL CENTER

Does New Jersey have more hospitals than it can support? Most people who understand the issue think that we do, and so does the state Advisory Commission on Hospitals, although the commission has not identified which hospitals should be closed. Many hospitals in New Jersey are facing financial difficulty, and not just because there are too many hospital beds (average occupancy is about 50%). Some of the difficulties are related to geographic location, some to poor management and poor business decisions, some to signing bad HMO contracts, and some to a variety of other or unique reasons. Nationally, academic medical centers have had particular problems. They have a teaching responsibility, and they often care for the most difficult and complex cases. Nevertheless, the teaching hospitals are essential to our educational system and to our medical care system.

A few hospitals have exhibited excellent management, have taken advantage of opportunities in the current challenging environment, and in the process have improved medical care in their communities. One such example is the Robert Wood Johnson University Hospital in New Brunswick, under the leadership of Harvey A. Holzberg.

This medical center (formerly called Middlesex General Hospital) has partnered with the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School and created a combined academic institution and community hospital that has enhanced medical care in the region and

served the needs of the medical education. In no small measure the success of this partnership is due to the vision of Mr. Holzberg, a hospital president with demonstrated good business judgment and clearly evident concern for quality medical care and the medical needs of the patients served by his hospital. He also is an administrator who understands doctors and works together with them.

Harvey Holzberg was president and chief executive officer of Jersey City Medical Center for nearly five years before coming to Robert Wood Johnson in 1985. He is a graduate of New York University and has an MBA from Baruch College.

The hospital that he serves as president and CEO has approximately 450 beds and treats more than 200,000 patients annually. They train between 300 and 400 medical residents in virtually all specialties. Specialized services include organ transplantation, cardiovascular surgery, a Level I trauma center, and the Cancer Institute of New Jersey.

In the brief statement that he has written for this issue of *New Jersey Medicine*, Harvey Holzberg outlines some of the achievements and goals of Robert Wood Johnson University Hospital. We are especially interested in the response to the recent Institute of Medicine report, with the formation of the Institute for Health Care Quality to identify and avoid medical errors.

In the interview appearing elsewhere in this issue, we found Harvey Holzberg to be frank, pragmatic, idealistic, and always proud of his hospital. Many of his comments are provocative, and all make for interesting reading.

**Paul J. Hirsch, MD**



## THE SURGEON'S RESPONSIBILITY

The surgeon's responsibility for pre- and postoperative care is, in theory, absolute and complete. In the United States, surgeons are taught that they must take the history of the patient's illness, perform a physical examination, and prescribe the necessary preoperative treatment to ensure that the patient is in optimal condition before surgery. The operation may be performed by the surgeon alone or with assistants, as indicated, but in any event the surgeon is solely responsible for the conduct of the procedure. This is true even though other specialists, such as anesthesiologists, commonly comanage surgical patients in the operating room and in the pre- and postoperative period. This is emphasized by a metaphor, as surgical trainees are taught that "The surgeon is the captain of the ship." (I am using the term in a literal sense and not from a legal/liability perspective.) Postoperative care is also an absolute and nondelegable responsibility of the surgeon. Physicians of other specialties—such as anesthesiologists, intensivists, and internists—often wonder why surgeons assert this burden of responsibility when so much care must be provided (especially in the operating room) by others. Yet the ultimate responsibility of the surgeon is widely recognized by all medical specialties, by other health care professions such as nursing and physician assistants, and by the public as well.

The responsibility of the surgeon is exercised with the help of many other health care providers, depending on circumstances. In the simplest situation, a patient may come directly to a surgeon with a small problem, such as a laceration or a splinter, in which case the surgeon provides all of the care, with the assistance of only an aide in the office. The patient may or may not ever return for a postop visit after such a small procedure. On the other hand, a patient with angina pectoris may have a family physician with

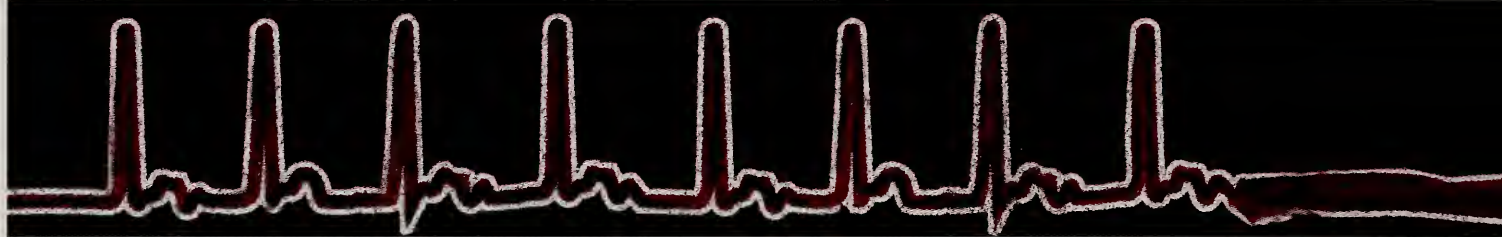
whom the patient has a long-term relationship, a cardiologist who has treated the patient for several months, and an angiographer who has seen the patient only once or twice. The entire history and a full physical examination will probably not be repeated by a cardiac surgeon, even if the patient is seen for elective coronary bypass surgery, and will surely not be performed if the patient is seen as an emergency in the cardiac catheterization laboratory. Immediate postoperative care will be managed by rotating teams of residents, cardiologists, cardiac nurses, and anesthesiologists. The operating surgeon would be physically unable to perform all of this care and unwise to attempt to. So the model of "complete responsibility" must be tempered by reality. Comanagement, or shared management, is essential, even though the surgeon bears the ultimate burden of responsibility. The other members of the surgeon's health care team may have terminal degrees and board certification, or they may be professionally certified assistants, students, aides, and volunteers. The nature of service rendered by the other members of the team depends on their training, their experience, and the need for their services.

Similar situations arise in wartime situations. Care may be rendered by many people, at various echelons, and it may be difficult or impossible for the operating surgeon to play any role in the pre- and postoperative care. Yet it is the tradition in surgery to be concerned about the outcome. Strenuous efforts are often made by surgeons to obtain follow-up information about their patients, even though they could not participate in the later aspects of their management. The point is, that surgeons traditionally feel responsibility for their patients, even though they may not be able to physically be present and to intervene when necessary. Thus, even in the impersonal relationship between a surgeon and an unknown combat casualty, the ethical surgeon wishes to assume the responsibility for postoperative care to the fullest degree possible.

George J. Hill, MD



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## A Vote for Universal Health Coverage

The gist of Dr. Robert S. Maurer's excellent article on suing HMOs ("HMO legislative proposals: should suits be permitted?" *NJM*, November 1999) is that legislative removal of the ERISA exemption would raise the premiums of health insurance to levels that the public would not tolerate.

Debates such as this as well as all of the studies to substantiate one or another point of view suggest that the system is flawed and needs to be replaced.

HMOs should be replaced by a single-payor system run by an authority and doctors put on salary. This would create universal health insurance. The money for such a system is in place and could simply be diverted.

The money saved from HMO profits, advertising, and administration would be enough to pay for the uninsured. Medical offices could dispense with the computerized business and divert those savings and energies to patient care. But most important, the system would be clean and medically driven. The needs of the patients would be paramount, and not governed by actuarial standards. Wouldn't that be refreshing?

Charles Harris, MD  
Island Heights

## United We Stand

In the "Newswatch" section of the 12/99 issue, under "Doctor Group Walks," Neil Weisfeld describes yet another instance of the inability of physicians to deal with HMOs. He later cites a comment from *Medicine & Health* referring to the possibility that medical groups that accept risk may try to engage in direct contracting with employers, and indicates that this may be a "silver lining" in the health insurance cloud.

In my opinion, this should not be considered a silver lining since, historically, physician-only groups have proven to be ill-equipped to compete with managed care companies. As doctors, we need to understand when we became managed care providers, after many years of being reactive independents, instead of an organized proactive group of practitioners, we merely became part of the product being sold by managed care. It is

evident that the time has come to seriously challenge the managed care and insurance companies. I offer a modest proposal that initially concentrates our effort where we can have the most influence: with our patients and other health care providers.

We have not done enough to educate patients and convince them that we care as much about them as we do about ourselves. Patients are the consumers of health care and the constituency the politicians listen to. They must be our allies!

No one forced doctors to join managed care organizations. Those who joined early, seeking a competitive advantage, created pressure on the rest, and we overlooked the fact that, without doctors, managed care has no product to sell. As a solo practitioner I successfully gave up managed care participation, not without some initial trepidation. I have encouraged a number of colleagues to do the same. We are at

least as well off, financially, and for us a sense of satisfaction has returned to the practice of medicine. It is clear we cannot successfully negotiate with the managed care companies, so if we do not resign, we give up the right to bitch as well as our independence. When 35% of your patient volume generates 1% to 15% of your income and you have to wait three to six months before you

### Requirements for letters

To submit a letter, e-mail ([info@msnj.org](mailto:info@msnj.org)) or mail your letter on disk to New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Letters should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgement. Letters may be published on MSNJ's Web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.



## Mail Stop

collect, that's a no-brainer. Just resign, and every month or so resign from another managed care plan. It may take one to two years to resign from them all, but it can be done successfully. We don't need to organize to resign. In fact, not organizing and resigning protects us from any threat of antitrust action.

Many of our hospitals are losing money because of managed care, and their survival is in jeopardy. We have seen nursing cutbacks leading to significant compromises in nursing care. If your hospital needs to drop a managed care plan, support that action by also resigning from the plan and join with nurses in

promoting patient care. Hospitals and nurses must be our allies!

If we hope to reverse the trend in health care we also need to compete with managed care; not among ourselves. Here in New Jersey, we have successfully formed a hospital (and doctor) provider organization called Qualcare. In only a few years it has become the fifth-largest managed care company in day-to-day operations, while doctors are well represented on all policy board and decision-making committees.

Qualcare does not play games with claims, and reimbursement is more than competitive. It has proven itself to be doctor-,

hospital-, and patient-friendly, and it is *ours*! We can compete successfully, and we can't be afraid to leave the bad guys.

The United States developed the best health care in the world through individuality, research, dedication, innovation, entrepreneurship, and cooperation. We can and must use these attributes to change the system. If we fail to challenge the managed care companies and fail to become allies of patients, hospitals, nurses, and other health care providers, we cannot reasonably expect our voice to be heard.

*Michael S. Kreitzer, MD*

*Summit*

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### Physicians Conference to feature literary and broadcast personalities

Bioterrorism and the media influence on patient behavior are just two high-visibility topics at the *Physicians Conference 2000*. The Conference Planning Committee has announced keynote speakers for two of the scheduled plenary sessions: *New York Times* bestseller author Richard Preston, PhD, and Bob Arnot, MD, medical correspondent for *Dateline* and the *Today* show.

The Medical Society of New Jersey, the Academy of Medicine of New Jersey, and more than 30 other specialty and medical-related organizations are coordinating the conference, which will be held in Atlantic City from May 5 through 7.

Richard Preston has set off international tremors within government and the public health community through his in-depth depictions of bioterrorism and germ warfare. His terrifying

chronicle of the Ebola virus, *The Hot Zone*, spent 42 weeks on the best-seller list, caused a frenzy of media coverage, and inspired several fictional adaptations (including the hit film *Outbreak*). His recent fact-based suspense novel, *The Cobra Event*, has been similarly acclaimed for its accuracy in describing a bioterrorism attack in New York City.

Dr. Stefan Epstein, a pathologist and a planning committee member, heard Preston at another meeting and believes that his message will ring true at the *Physicians Conference*. "Preston held the large audience of pathologists and medical technologists spellbound, as he detailed three years of research to prove that the threat of bioterrorism in America is very real," said Dr. Epstein. "After reading *The Cobra Event*, President Clinton took several steps to see whether the US government is prepared for such an attack. The results prove that we are not."

Direct-to-consumer advertising and media coverage of medical

issues have definitely affected the way that consumers approach health care. As a medical correspondent for nearly 20 years at CBS and NBC, Dr. Bob Arnot is well-qualified to discuss how changes in media coverage have influenced patient behavior in the past and will continue to do so.

A former emergency room physician, Dr. Arnot also served as national medical director of the National Emergency Service, where he was responsible for the education and quality control of 2,500 physicians in 116 hospitals across the country. He is well-known for his award-winning documentaries and his five books, while he continues to write a monthly newsletter and a column for *Self* magazine.

The Conference Planning Committee is finalizing arrangements with a final keynote speaker. Rep. Charles Norwood (R-GA), who is the sponsor of the House Federal Patient Bill of Rights, has been invited to participate in the Sunday general session. 



### INTEGRATION OF MD CONSULT INTO ELIXIS WEBCODER TOOL CREATES NEW RESOURCE

Physicians will now be able to chart patient information and access trusted clinical reference materials within the same online application, thanks to a new alliance between Elixis Corporation and MD Consult.

Under the agreement, Elixis will integrate MD Consult's full-text clinical information service into its WebCoder charting tool, providing physician subscribers with immediate and unlimited access to both services. Because WebCoder is completely Web-based, physicians will have access to MD Consult at the point of care within the course of their normal work flow. The MD Consult service will be bundled with the WebCoder base subscription. For more information, visit Elixis at [www.elixis.com](http://www.elixis.com) or MD Consult at [www.mdconsult.com](http://www.mdconsult.com).

### NEW STANDARD FOR FINDING MEDICAL INFORMATION ON THE WEB

MDchoice.com, a new medical Web portal launched by leading academic physicians, features a comprehensive search engine to help medical professionals quickly find specific, credible health-related information such as peer-reviewed medical education resources, full-text journals and textbooks, medical photographs, and radiologic studies.

Here are just a few of the resources MDchoice offers:

- A Search Wizard feature that categorizes the Web's medical resources and keeps track of the type of information and subject matter found on particular Web pages to provide efficient, reli-

able, and comprehensive results-oriented searches.

- A link and guide for professionals to search MEDLINE, the National Library of Medicine's database of medical journal articles.
- Interactive critical care patient simulators, wherein professionals can test their knowledge and skill by treating critical care patients in a "virtual emergency room."

Visit [www.MDchoice.com](http://www.MDchoice.com) for additional information.

### ONLINE DOCTORS YELLOW PAGES LAUNCHED

MedNA launched its first of many Web-enabled applications for physician practices and their patients. Doctors Yellow Pages, located at [www.medna.com](http://www.medna.com), offers a comprehensive online directory that allows physicians to add information about their practice, including style, insurance participation, hospital affiliation, office hours, location, and more.

### AMA COLLABORATES ON INTERNET SAFEGUARDS

The AMA and Intel Corporation have launched a program that will introduce new safeguards for medical confidentiality on the Internet, and the AMA has announced the development of [medem.com](http://medem.com), a health information Web site cosponsored by specialty societies offering credible, peer-reviewed health information. This site will also allow patients to access information and to electronically communicate with their physicians.

## BOOKMARKS

<http://www.medcatalog.com>

A free source for medical products and supply information from hundreds of companies offering their information and expertise.

<http://www.rxlist.com>

A useful site providing information about the description of brand or generic name drugs, indications for use, normal dosage and methods of administration, and adverse effects.

<http://www.proxyMed.com>

Clinicians can develop a Web site that serves as a personal home page, while exchanging clinical and financial information with payors, labs, pharmacies, suppliers, and patients.

<http://Go-Health.net>

Administrative and clinical-information sharing for a geographic area's physicians, plans, and hospitals.

[www.msnj.org](http://www.msnj.org)

Members of the Medical Society of New Jersey (MSNJ) will want to go to MSNJ's Web site every day for the latest news and perspectives.



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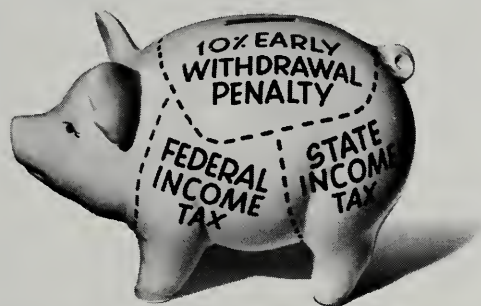
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# Harvey A. Holzberg

*President,*

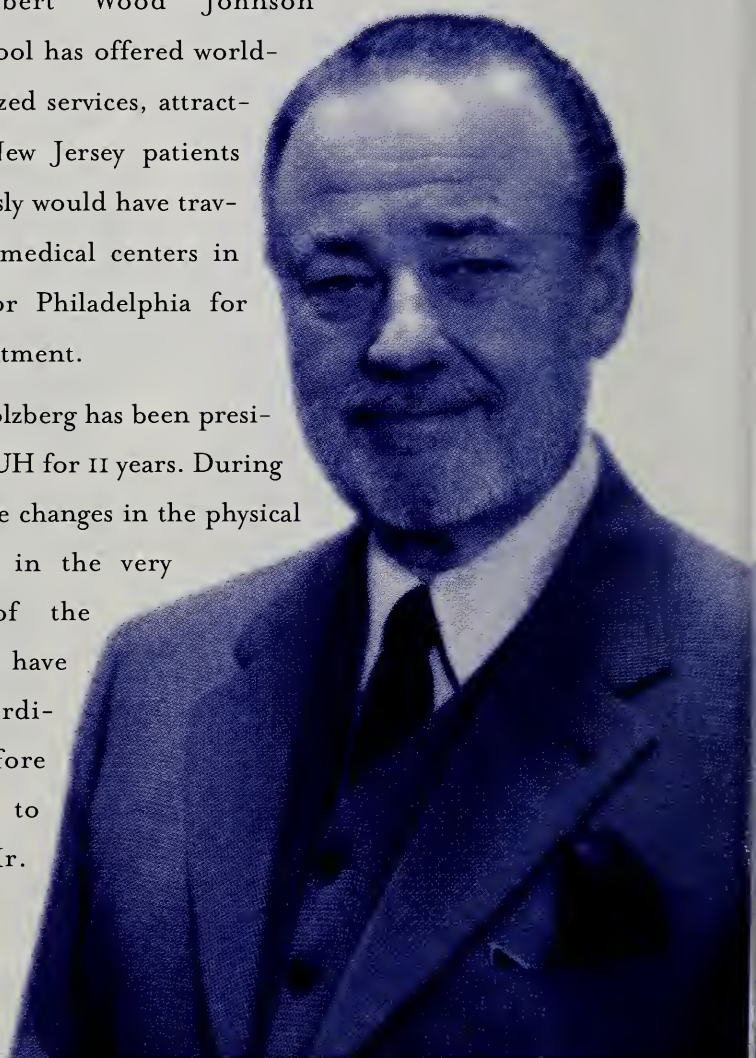
*Robert Wood Johnson University Hospital*

Robert Wood Johnson University Hospital is the principal hospital of the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School. The hospital provides specialty and subspecialty care; offers primary, tertiary, and quaternary services; and presents a unique effective melding of university faculty and community physicians. Specialty and comprehensive services include: the Bristol-Myers Squibb Children's Hospital at Robert Wood Johnson University Hospital (a new building is under construction), the Cancer Hospital of New Jersey, the Center for Innovations in Bloodless Surgery and Medicine, the Clinical Neurosciences Center, a Level I trauma center, and the Heart Center of New Jersey (a 125-bed "hospital within a hospital"). And orchestrating all of these and other units so that they function as a coordinated institution is the dynamic and energetic president of the hospital, Harvey A. Holzberg.

The nature of the relationship of the Robert Wood Johnson University

Hospital (RWJUH) with the Robert Wood Johnson Medical School is, we believe, uncommon. It is a real partnership of equals, and that fact may have given RWJUH the ability to maintain a strong base of community physicians, an important factor in its success in the central New Jersey region. At the same time, the outstanding faculty recruited by the UMDNJ-Robert Wood Johnson Medical School has offered world-class specialized services, attracting many New Jersey patients who previously would have traveled to the medical centers in New York or Philadelphia for care and treatment.

Harvey Holzberg has been president of RWJUH for 11 years. During that time, the changes in the physical facility and in the very character of the institution have been extraordinary. Before coming to RWJUH, Mr.



Holzberg was president of Jersey City Medical Center. He is a graduate of New York University and has an MBA from Baruch College in New York.

*New Jersey Medicine* (represented by Medical Society of New Jersey Executive Director Vincent Maressa and *New Jersey Medicine* Editor-in-Chief Paul Hirsch) interviewed Mr. Holzberg in his office at the hospital on a rainy and busy Friday. Because of construction (the new children's hospital), he recently located to new quarters. Three members of his staff were also present during our discussions: Judith E. Burgis, senior vice president, corporate services; Barbara Kerwin Jones, vice president, public and community affairs; and Marla Diamond, director, media relations.

Harvey Holzberg was proud of his organization and its professionals and proud of the services that RWJUH has brought to the New Brunswick community and to the area. He answered our questions about his own organization, about hospitals in New Jersey, about physician workforce needs, and about managed care, frankly and without hesitation.

**New Jersey Medicine:** How many hospitals are in the Robert Wood Johnson Health network?

**Mr. Holzberg:** Our network includes eight hospitals: seven acute-care hospitals, and the

Children's Specialized Hospital, which provides pediatric rehabilitation and long-term care. In addition, we have four federally qualified community health centers and Presbyterian Homes and Services, which is one of the largest assisted-living and long-term care providers in New Jersey. So, it is a well-rounded network. We have more than 2,200 beds, and we employ more than 10,000 people.

**NJM:** Which are the seven acute-care hospitals in the Robert Wood Johnson Health Network?

**Mr. Holzberg:** Bayshore Community Hospital in Holmdel, CentraState Healthcare System in Freehold, Rahway Hospital, Raritan Bay Medical Center in Perth Amboy and Old Bridge, Robert Wood Johnson University Hospital in New Brunswick, Robert Wood Johnson University Hospital at Hamilton, and Warren Hospital in Phillipsburg.

**NJM:** That's quite a geographic spread. How is the network administered?

**Mr. Holzberg:** The network is independent. We do not intervene in the governance or administration

of the network hospitals. But we are clinically integrated, and that is the important point. The chief medical officers, the chief nursing officers, and the chief executive officers all meet on a regular basis.

We have all established the same performance outcomes measurements. The chief medical officers have developed benchmarks for each diagnosis. Every hospital in the network is measured against those benchmarks and has agreed to meet them. For every diagnosis, at least one or two hospitals do not currently meet the benchmarks, and no hospital meets them all. We are all working toward meeting them, using common protocols. We have a common formulary for the entire network.

**NJM:** With that approach, with clinical integration and an aim of consistency, is it a problem that you do not have administrative consistency to the same degree?

**Mr. Holzberg:** No. We began initially as a very loose system, developed through trial and error. We had contracts that allowed hospitals to enter and leave the network at will. That did not work well. We now have five-year contracts, and in sports jargon, they are "no cut." The board of the network consists of members from the board of each hospital, the CEO of each hospital, and members of the medical staff of each hospital. Although each hospi-

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tal has its own organization, the chief medical officers and CEOs have all adopted and agreed to the established benchmarks.

**NJM:** So, while there may be variables in the executive's decision-making or administering of the protocols, the goal is that you have the same product at the end.

**Mr. Holzberg:** Yes. And you must meet the standards. The chief medical officers are enamored by it. For the first time, it has given them not just a goal but the clout to meet that goal, because the boards and the chief executive officers have all agreed that this must be done. And, of course, there is the matter of pride. Since no one hospital meets all of the benchmarks, we are all striving to do so, and we are determined that we will.

**NJM:** That sounds like a reasonable approach. You have set goals and standards but do not micromanage the separate units.

**Mr. Holzberg:** And that is why we developed a process in which we do not control the administration or the governance of the institution. But we do very strongly influence the quality of care. And that is what it is really all about.

Now, within the network, there are three hospitals (Robert Wood Johnson University Hospital,

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Robert Wood Johnson University Hospital at Hamilton, and Children's Specialized Hospital) that are within the Robert Wood Johnson Health System. In addition, we are currently finalizing negotiations with two other hospitals, which I cannot identify at this time. In these, we are involved in the governance and administration of the hospitals, including approval of board members, the CEO, the budget, and the strategic plan. But I am not a believer in strong centralization. Decentralization is a much better way to manage. I do believe in delegation, I do delegate, and I do not micromanage, although no matter how large the network or system becomes I still consider myself a line hospital administrator. It's what I love, and it's what I am best at.

We are, by the way, the only health system in New Jersey that has a med-

ical school as a partner, adding research and educational components. I think that is an added value.

**NJM:** With regard to your affiliation with the medical school, in most instances where that occurs, the school dominates the hospital. Here it appears that the school and the hospital system are partnering.

**Mr. Holzberg:** That's correct. I think "partnership" is the key word: it is a real partnership with the medical school. Medical schools have changed dramatically in the past few years. In the past, when physicians referred a patient to a medical school they never saw the patient again and perhaps never heard from the consultant. Medical schools are now trying very hard to be responsive—to provide specialty services and get the patient back to the referring physician as soon as possible.

An advantage to the affiliated network hospitals is the ability of the medical school to provide hard-to-get specialties for the hospitals, such as pediatric subspecialists or neurosurgeons, when necessary.

**NJM:** Does the combination of faculty and community physicians at RWJUH create problems for the hospital?

**Mr. Holzberg:** In our institution, 50% of our admissions are from the faculty, and 50% are from community physicians. They cooperate with

the hospital and with one another. We have no real town-gown conflict. This relates to the leadership of both groups and of the hospital. Each physician group is important to the other and to the hospital. Referral patterns reflect a mingling of faculty and community physicians. This has taken time, but it too reflects a partnership of our hospital with all of its physicians.

**NJM:** Earlier, you discussed the clinical features of the network. Are there significant nonclinical aspects to the network? Are there any cost-saving features?

**Mr. Holzberg:** We have looked at pragmatic services that we could provide. Because of economic and other problems, it was not feasible. Rather than force the issue, we'll wait until we're ready. So now, it is primarily clinical, but we do have many other things that we do in the network. We share a common agency for per diem nurses. We have a grant from the US Agency for International Development establishing, through the network, a cardiovascular wellness center in Minsk, Belarus. We have a contract with the Department of Developmental Disabilities to establish case-management programs. We also have a contract with the American Arbitration Association to provide the physician expertise for review of

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DEFINES IT AS.**

management of patients injured in motor vehicle accidents. Every one of these programs involves different members of the network.

**NJM:** Your network 15/30 emergency-room guarantee has received national recognition. How does it work, and has it been successful?

**Mr. Holzberg:** This emergency-department policy promises that in 15 minutes or less, a triage nurse will see the patient; and within 30 minutes, the patient will be seen by a physician. And that is a meaningful interaction with them, not a "Hi, I'll be with you later" visit.

We began the 15/30 guarantee here at RWJUH in March 1995. We had just expanded the emergency department, and I continued to receive letters about the long waits that people had. During my regular meetings with physician groups, I also heard from them about the inordinate waits that their patients had. And we had a huge percentage of walkouts.

We had to do something dramatic to turn around the image of our emergency department. Patients thought that it was a great place for major trauma, but that otherwise the wait was too long. We decided that we would see all patients within 15 minutes. The staff was challenged and told that they should reengineer the process. They met the challenge, beginning with changes in the registration procedures, so that with very little additional staff and practically no additional room or equipment, we could accomplish this. Physicians have championed the idea; they and the staff made it work. It has been a huge success. Emergency-department visits increased dramatically, approximately 15% in the first year. That is especially significant for us, because we get about 35% of our admissions through the emergency department. So, we had not just an increase in emergency department visits, but also a rise in admissions along with it.

**NJM:** What is the guarantee that you provide as part of this policy? How has it worked out?

**Mr. Holzberg:** If a patient is not seen within the guaranteed times, there is no charge for the visit by either the hospital or the physician. After our first two years, we returned money 22 times, out of nearly 50,000 visits annually. After



successfully implementing this program here, we suggested it for the network. Each of the other hospitals experienced immediate gains in emergency visits and also saw a corresponding increase in admissions. Every hospital in the network is using this program now. We have been told that this is the only true guarantee in the entire hospital industry.

**NJM:** Doesn't the policy encourage nonemergent visits?

**Mr. Holzberg:** I spent much of my career before coming here trying to keep nonemergent patients out of the emergency room. It is impossible. Efforts to keep these patients out only aggravate the patients and the emergency room staff. One of the problems is that it is difficult to define an emergency. It took me a long time to realize that an emergency is whatever that patient defines it as. An episode that may seem clearly nonemergent to medical professionals can be frightening to the patient. We've stopped trying to keep nonemergents out of the emergency room, because it does not work. We do not encourage these visits, and we have not tried to establish the emergency room as a primary care center. We do not have them return for follow-up care; they are always referred to their physician or to the Chandler Health Center.

[The Chandler Health Center is a federally qualified health center that cares for underserved populations.]

**NJM:** Although you have increased your admissions, most New Jersey hospitals have experienced declining admissions. Are there too many hospital beds in New Jersey? Do you see further consolidation among hospitals in New Jersey?

**Mr. Holzberg:** There are probably 20 to 30 too many hospitals in New Jersey. It is not simply a matter of too many beds. Closing wings and nursing units does not provide sufficient savings and has no impact on the fact that too many hospitals make competition very difficult. There was a point, until about a year ago, when a hospital in financial difficulty would offer itself to a system and be taken in. All that accomplished was that the system would keep open a hospital that probably should have been closed. That hospital also became a financial problem for the

system. I do not believe that will happen any longer. We never did that. All of the hospitals in our network were profitable when they joined us.

One of the reasons that systems were eager to bring in other hospitals was the sense that horizontal integration was the way to go. If you had enough hospitals spread out across the state, it would provide more clout with managed care organizations. That was not the case. The managed care organizations would indicate that there might be only three hospitals in the network or system in which they were interested and demand concessions in order to include the others. Therefore, having more hospitals often made systems weaker, not stronger, from a negotiation perspective.

I think that in the future, we will see sensible mergers. A sensible merger may involve hospitals that are geographically close, allowing real clinical rationalization.

We will see a number of hospitals failing. We must protect hospitals in inner cities and in some suburbs and rural areas where there is only one hospital serving an area. But we must accept the fact that most of the inner cities have too many hospitals. Newark has too many, Jersey City has too many, Passaic has too many, Trenton has too many, Camden has

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too many. We must be very careful that we have enough hospitals, but we also must let the market determine which hospitals will close in any area. For example, in Newark, we should let the market determine which one of the three hospitals will close, and then we must ensure that the remaining two remain viable.

**NJM:** Have you observed an increase in the number of physicians in this area, through the number that apply for privileges in your institution?

**Mr. Holzberg:** To some extent, yes. I am not sure that that is the result of having too many physicians or the result of the growth of this institution as an academic health center. I think it is more the latter than the former. We now have a medical staff of about 1,300 physicians, which for a 448-bed hospital is a huge number of physicians. I do not think that is the result of having too many physicians. I think it is the result of physicians wanting to be on the staff of this academic health center.

**NJM:** Does that number of physicians put a lot of pressure on your operating rooms and other facilities?

**Mr. Holzberg:** It does. For example, our bed occupancy today is 104%. We have just added four new operating rooms. We purchased an

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ambulatory surgical center. We now have five cardiac catheterization labs. We opened a new nursing unit of 18 beds practically overnight; we found that we had a building that we could add a new floor to, even though we are currently putting up two new hospital buildings right now. We are building a 93-bed cancer hospital and a 70-bed children's hospital.

But, I do not think that there are too many physicians, or too many specialists, either in my community or in New Jersey.

**NJM:** But many believe that, at the least, physician incomes are driven down by an oversupply.

**Mr. Holzberg:** I do not think that changes in physician income have anything to do with there being too many physicians. I think that it is related to the managed care system. The system that we call managed care is really more a system of managed costs, and that is what is controlling physician income. I do not believe that managed care companies would pay more if there were fewer physi-

cians. I think it is a matter of physicians saying, "I am not going to accept less than what I am worth." I believe that physicians should once again receive the incomes that they frankly deserve, given the costs of going to medical school and long residency and fellowship programs. I think that physicians are getting the short end of the stick right now. I do not think that has anything to do with the fact that there may be too many. On the contrary, I fear that now the best and the brightest will no longer go into medicine but will go into finance or other fields.

**NJM:** Do you believe, then, that the number of residency positions does not need to be decreased?

**Mr. Holzberg:** We must look at the quality of the residency programs. We must determine which are good programs and which are there for service. I appreciate the need for the service, but we must find a way to pay for the service other than through a residency program. It is not a matter of the number of residents so much as it is a question of the quality of the programs.

**NJM:** Where should payment come from?

**Mr. Holzberg:** All governmental-ly controlled HMO activity ought to have a separate pool for resident education. HMOs should pay for their share of graduate medical education and charity care. I would be



concerned about establishing a separate rational pool for graduate medical education, rather than include it in Medicare rates, because I fear that it would be eroded. Perhaps there could be some type of block grant to the state, which would then be distributed.

**NJM:** You have just raised the issue of charity care. That is an important and controversial issue in New Jersey. How should this problem be solved?

**Mr. Holzberg:** It is essential to realize that you cannot pay for \$600 million in charity care, with \$320 million. This hospital gives the most unreimbursed charity care in the state of New Jersey. We give \$6 million or \$7 million in charity care each year and get zero dollars for it. The current formula, through which a hospital would not receive reimbursement for charity care if it had a profit margin above a given level, was supposed to be temporary. I agreed to it, on that basis. Each hospital was to eventually be paid in accordance with the amount of care it gave. We must add dollars to the pot, we must include physicians, and we must include all hospitals and not just those that are currently receiving payment for charity care. As the number of uninsured patients increases, everyone is giving more and more charity care. We at RWJUH have an eroding margin. As

the margin dwindles, a hospital does not automatically become eligible, because it is based on a three-year average. We should cover all hospitals, and we must start to cover physicians in charity care.

**NJM:** Some hospitals that have signed disadvantageous managed care contracts may actually be better paid for charity care.

**Mr. Holzberg:** That may be true. Charity care should not support bad business decisions, including accepting contracts below costs or other decisions that have nothing to do with providing charity care. Some hospitals have felt compelled to accept below-cost contracts. When a hospital has a 50% occupancy rate

WE MUST PROTECT  
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FACT THAT MOST OF THE  
INNER CITIES HAVE TOO  
MANY HOSPITALS.

and a managed care company that controls 15% of that hospital's volume states that it will pay 50 cents or 60 cents or 70 cents on the dollar, it is hard for that hospital to walk away.

**NJM:** Was this part of your decision making when you recently declined a contract from Aetna-US Healthcare?

**Mr. Holzberg:** We are back at the negotiating table with Aetna-US Healthcare. We will not accept rates that do not include graduate medical education, charity care, and all of our costs. I am hopeful that we will have a contract with them, but we will not lose money on it; we cannot do that. I would rather lose 15% of our business than lose money on 15% of our business.

**NJM:** Do you believe that the Aetna-Prudential HealthCare merger has made them difficult to deal with?

**Mr. Holzberg:** Yes!

**NJM:** We think that as a result of this merger, we need to see a bit more aggressive regulation and possible legislation, enabling doctors and hospitals that are independent of each other to collectively negotiate with a dominant payor that has a 15% or greater market share. Do you support that kind of approach?

**Mr. Holzberg:** Yes. It may not be the most effective way for hospitals, but doctors must have an effective

way to negotiate with large insurance companies. They need a way to bargain collectively.

**NJM:** Are there particular problems, other than purely financial ones, that you face as an academic center?

**Mr. Holzberg:** As an academic health center, we must be state of the art. We must remain cutting edge. That means we require very expensive equipment and staff. Because of our relationship with the medical school, we can put up a new program, for example our transplantation program, much more quickly than anyone else can. We are bringing up a pediatric cardiac surgery program. It is very expensive, but we have to do these things. A mistake that we hope not to make is to cut critical programs in the name of cost containment.

**NJM:** Historically, many New Jersey patients have gone out of state for medical care. What are you doing to let people know that RWJUH really is a state-of-the-art facility?

**Mr. Holzberg:** More and more people do recognize our excellence. We have reduced out-migration of patients from about 50% a few years ago to about 16% now. We have the advantage of a highly educated and affluent community. Until about 10 years ago, many of these people went for the most part to New York and Philadelphia. That has reversed,

I FEAR THAT NOW THE  
BEST AND THE BRIGHTEST  
WILL NO LONGER GO  
INTO MEDICINE BUT WILL  
GO INTO FINANCE OR  
OTHER FIELDS.

because we have new specialized services such as the Cancer Institute of New Jersey, cardiac surgery, heart and kidney transplantation, and subspecialty pediatrics. People realize that now.

**NJM:** We have noticed a lot of out-migration, because the development of university teaching hospitals in New Jersey was relatively late. Even as that occurred, there was not an extensive outreach by the medical school to the clinical community, and the individual physicians feared referrals to a large university center.

**Mr. Holzberg:** You're right. School ties play a role, and so does personal outreach on the part of faculty physicians. The medical school and faculty are coming to that. It is often difficult for faculty, with clinical, research, and teaching responsibilities, also to have the luxury of being able to go out and reach out. But there is recognition of how important that has become, and although it still needs a lot of work, it is changing.

**NJM:** Earlier in our conversation, you mentioned the Cancer Institute of New Jersey. Could you tell us more about it?

**Mr. Holzberg:** The Cancer Institute of New Jersey is a miracle! It was established in 1990 with a \$15 million planning grant from the National Cancer Institute. It generally takes about 10 years to go from the planning grant to becoming a National Cancer Institute-designated program. Dr. William Hait, director of the Cancer Institute, accomplished this for us in about three years. The growth of the center has been about 8% monthly. It has outgrown its building within a few years, and we must expand it. Have you seen it? You must.

With this statement, Mr. Holzberg and Ms. Burgis took us on a tour of the Cancer Institute. It is an extraordinary facility, incorporating offices, research laboratories, and patient treatment areas, in an open and surprisingly inviting environment.

We were impressed with the ways in which this exceptional hospital is meeting the challenges of the current changing environment. RWJUH is a resource for its local and regional community and is increasingly a resource for the entire state of New Jersey and beyond. ■



## The Continued Challenges of Health Care

When I first entered the health care arena, I quickly became aware of the difficulty some of our citizens faced in obtaining access to quality health care close to home and at a cost that they could afford. I became an early advocate and promoter of neighborhood health centers, which brought physicians, nurses, and other caregivers into the community. One of the proudest achievements in my career was the role I played during my tenure at Lutheran Medical Center in Brooklyn in the development of the Sunset Park Family Health Center, the largest federally qualified family health center of its kind in the country.

There can be no doubt that no matter what challenges we face in the demands of today's health care environment, we can never abandon the people who need our help the most—the medically underserved. I remained committed to that mission when I joined Robert Wood Johnson University Hospital (RWJUH) 11 years ago. At that time, even New Jerseyans with strong economic resources believed that if they needed specialty health care services, they had to leave New Jersey to get them. I was determined to show patients that sophisticated medical resources were available at RWJUH and if some services were not available, we would develop them. We have been successful in that effort and now all patients are assured of receiving advanced services and technology right here in New Jersey at RWJUH.

As the principal hospital for UMDNJ-Robert Wood Johnson Medical School, RWJUH has become recognized as an academic health cen-

ter, setting the highest standards and in constant pursuit of excellence. We apply these principles every day to achieve our mission of providing the finest patient care, conducting cutting-edge research, educating the health care professionals of tomorrow, and providing outreach to the communities we serve. Many of you are aware of national efforts to reduce the incidence of medical errors. As further evidence of our allegiance to our mission, I want to take this opportunity to announce the formation of the Institute for Health Care Quality. We believe the institute will be a national model to avoid and reduce medical errors in hospitals. Our outstanding medical staff of community-based physicians along with the full-time faculty physicians of the Robert Wood Johnson Medical School will provide the leadership for this important initiative.

I am very proud of what we have accomplished at RWJUH. What increasingly concerns me, however, is the lack of commitment by our health policy makers to find a permanent solution for the funding of graduate medical education (GME). Here at RWJUH and at academic health centers across the country, we have the responsibility to educate the health professionals of tomorrow—physicians, nurses, pharmacists, and a myriad of allied health professionals. I add my voice to the chorus of health care experts who have described GME as a public good, assuring society of its future caregivers. Yet academic health centers are under siege nationally; many are experiencing large negative margins and feeling the impact of drastically reduced reimbursement

from the Balanced Budget Act and managed care contracts, with mergers failing and not producing the anticipated cost efficiencies. These issues need and deserve national attention, and Congress has begun to pay attention only recently. Closer to home in New Jersey, these are among the many issues causing great difficulties for hospitals throughout the state.

Today, internationally renowned medical experts in all specialties have been recruited to our campus because of our academic environment and continued support for educational, research, and clinical opportunities. As we anticipate the next generation of medical advances, I salute those who have given of themselves to RWJUH: physicians, members of the Board of Directors, employees, community members, volunteers, and auxiliaries. We have worked together with a common goal to give all patients, no matter what their economic status, access to advanced technology and programs ranging from primary care through tertiary and quaternary services previously available only at out-of-state institutions. Included among our Centers of Excellence are: the Heart Center of New Jersey, the Vascular Center of New Jersey, the Center for Heart and Kidney Transplantation, the Bristol-Myers Squibb Children's Hospital at Robert Wood Johnson University Hospital, and the Cancer Institute of New Jersey, among others.

As we begin the new millennium, we remain committed to push the frontiers of medicine to improve health care on a global level as well as in the heart of our community.

**Harvey A. Holzberg, FACHE**

*President and Chief Executive Officer  
Robert Wood Johnson University Hospital*



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# MEDICAL SCIENCE IS THE KEY TO SUCCESS IN THE 21ST CENTURY

Rep. Rodney P. Frelinghuysen

As the "medicine cabinet of the nation," if not the world, New Jersey is poised to remain that leader into the 21st century. For those in desperate need of new life-saving medicines and for those whose job it is to diagnose and to prescribe, New Jersey's pharmaceutical industry continues to provide hope. The federal government must not get in the way of the industry's ability to continue providing that hope. We must not harm research efforts; we must foster them and continue to provide both patients and doctors with the most advanced tools to fight disease and illness.

If headlines are to be believed, their story of success proves we're headed in the right direction:

- *Wall Street Journal*, "AIDS Drug Shows Promise Against Resistance"
- *The New York Times*, "Study Finds Drug Limits Spread of Flu"

- *Geriatrics Magazine*, "Osteoporosis drug reduces risk of breast cancer"
- *Wall Street Journal*, "Schering-Plough Drug Fighting Brain Tumors Gets FDA Approval"
- *Wall Street Journal*, "Drugs in Development for Children Rise by 11%"

These are just a few recent news accounts of the exciting progress made by the pharmaceutical industry in solving some of the world's most pressing illnesses and diseases. While the key to the industry's success has been the significant reinvestment of profits in new research and development—this year, pharmaceutical companies will invest nearly a quarter of their profits, or \$24 billion, back into research and development efforts—profits alone are not enough.

We must encourage more collaboration between our physician

researchers at academic institutions, our pharmaceutical industry, the federal government, the Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the National Science Foundation (NSF).

Such collaborations are important and necessary because in our own backyard we have all the ingredients for success:

- New Jersey is home to some of the most outstanding medical researchers in the nation at UMDNJ and other hospital systems, and our state is the home of the New Jersey Institute of Technology, Stevens Institute, Princeton and Rutgers Universities, and other research powerhouses.
- We are the pharmaceutical capital of the world, with the industry



paying at least a quarter billion dollars annually in state and local taxes.

- New Jersey is ranked 7th nationally in high-tech employment in electronics and information companies—the resources and brainpower are here for sharing, transmitting, and calculating information.
- Our state has more corporate headquarters than any other state and about 60,000 men and women are employed by pharmaceutical companies.
- We have an educated population, a higher per-capita income and, I suspect, more physicians, scientists, technicians, and engineers per capita than any other state.
- We have a congressional delegation that supports increasing investment in research and development (R&D).

Interestingly, 10% of all government and industry R&D dollars spent nationally are spent here in New Jersey. I would like to see that number increase, and as New Jersey's only member of the House Appropriations Committee, increasing federal dollars both for New Jersey and our nation is one of my top priorities. Last year I was able to secure \$3 million from the Department of Defense budget for the Dean and Betty Gallo Prostate Cancer Research Institute at the

New Jersey Cancer Institute at the Robert Wood Johnson Medical School. To give you a more complete idea of what the federal government is spending for medical and other research in New Jersey, last year:

- NSF grants to New Jersey totaled \$77 million.
- CDC grants to New Jersey totaled \$52 million.
- NIH grants to New Jersey totaled \$125 million, with much of those funds going to Rutgers, UMDNJ, Princeton, Stevens, and other universities as well as private research facilities.

Of particular interest to me is the NIH. Congress again increased the NIH budget this year by 15%, and as in the past, I expect New Jersey companies and researchers will benefit from this increase since NIH will be

THIS REVOLUTION HAS  
COME ABOUT THANKS TO  
THE EFFORTS OF MANY  
DOCTORS AND MEDICAL  
PROFESSIONALS WHOSE  
LONG-TIME COMMITMENT  
TO THEIR PATIENTS  
EXTENDS BEYOND THE  
BEDSIDE AND INTO THE  
LABORATORY.

able to advance its basic research efforts.

Nearly 82% of NIH's budget goes toward extramural awards to private and public research facilities, and according to NIH, this collaboration has been a critical component of its core research efforts. Cooperative research and development agreements have provided a mechanism through which NIH scientists and pharmaceutical companies can better translate basic NIH research findings into new medicines for patients and doctors. For example, the unprecedented pace of the development of new drugs to treat AIDS highlights the productive relationship between the government and industry research.

These successful collaboration efforts, and the bipartisan support for doubling the NIH budget over the next five years, is largely due to NIH director Dr. Harold Varmus's leadership. A Nobel laureate for his own cancer research, Dr. Varmus visited New Jersey in November at my invitation to give a talk at Drew University in Madison about the direction of NIH's future research.

Dr. Varmus has said in Congressional testimony, "We are in the midst of a revolutionary phase of biological research . . . Never before have we had such powerful research tools to develop clear understandings of fundamental . . . processes to study and treat diseases."

This revolution has come about thanks to the efforts of many of you, doctors and medical professionals whose long-time commitment to your patients extends beyond the bedside and into the laboratory. This research revolution is also due to the ongoing partnerships between the federal government and the research community.

I believe we need to foster these partnerships: we need to do all we can to strengthen the involvement of the federal government in providing opportunity for basic research in a variety of settings.

Congress is committed to increasing the US investment in R&D, and we have increasingly done so since 1995. I assure you that I am committed to increasing funding for research and development in all fields.

During the Cold War, often national security issues drove our R&D spending—today, some of those issues still exist, but in the 21st century especially, as a nation, we must declare war on the diseases and illnesses that plague us and the world. New Jersey is well-equipped to break new ground in collaborative efforts that over time could prove more cost-effective, change the world, and save many, many more lives.

I will continue to be an ardent advocate for New Jersey's medical research community by promoting international trade, protecting

MY NEW JERSEY  
COLLEAGUES AND I WILL  
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MEDICAL DECISIONS TO  
PATIENTS AND THEIR  
DOCTORS AND THAT THIS  
FUNDAMENTAL REFORM  
BECOMES THE LAW  
OF THE LAND.

intellectual property rights, improving Medicare prescription medication coverage without harming research efforts, fighting restrictive drug formularies, and making the FDA more accountable.

I will also continue to be outspoken in my work to improve health care in the US. The passage of Norwood-Ganske-Dingell's Patient Bill of Rights, HR 2723, was a great victory in the House of Representatives, but our work is far from over. My New Jersey colleagues and I will work to insist that managed health care is reformed so we return medical decisions to patients and their doctors and that this fundamental reform becomes the law of the land.

In the past century, medical achievements have been among the world's most remarkable; as this new century gets under way, we renew our commitment to research and the development of new medicines so doctors will be able to save more lives and our families will worry less about catastrophic illness and disease.

I started this piece with a sampling of recent headlines that tell the story of recent successes in pharmaceutical research. I end it by writing my own headlines, a sampling of the news that I hope to see, and I am positive you and your patients do as well, as this new century unfolds:

"Nobel Prize Awarded to Cancer Vaccine Research Team"

"No Deaths from AIDS this Year; Cure Saves Millions around the World"

"Alzheimer's Discovery Relieves the Fears of Older Americans"

"21st Century Prenatal Care Eliminates Birth Defects"

"Walking to Podium, Christopher Reeve Accepts an Oscar for Lifetime Achievement Award"

Kind of gives you chills, doesn't it? What a century it shall be. ■

*Congressman Rodney P. Frelinghuysen is in his third term as representative from the 11th District, which comprises Morris as well as parts of Essex, Passaic, Somerset, and Sussex Counties. He remains New Jersey's only member of the House Appropriations Committee.*



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# IMPROVING PNEUMOCOCCAL VACCINATION RATES FOR ELDERLY PATIENTS

LAST YEAR, THE PNEUMOCOCCAL VACCINATION RATE OF 32% IN OUR ELDERLY CLINIC POPULATION WAS, LIKE THAT OF THE STATE OF NEW JERSEY, WELL BELOW THE HEALTHY PEOPLE 2000 TARGET OF 60% TO 80%. DURING A NINE-MONTH PERIOD IN WHICH INTERVENTION STRATEGIES, INCLUDING EDUCATION AND STANDING ORDERS FOR NURSES, WERE IMPLEMENTED, WE ACHIEVED AN IMPROVED RATE OF 63%.

*Todd Gruber, MD, MPH, FACP*  
*Rao Marada, MD*

Pneumococcal disease is an important cause of morbidity and mortality in the US and results in more than 40,000 deaths per year.<sup>1</sup> The rate of pneumococcal bacteremia is 280 cases annually per 100,000 persons older than the age of 70. This rate is 14-fold higher than that for young adults.<sup>2</sup> Because pneumococcal disease is potentially preventable through immunization, attention is being focused on improving vaccination rates for susceptible groups such as the elderly population.

In May of 1998, the New Jersey Peer Review Organization (PRO) mailed an alert to the state's health care providers, indicating that the

pneumococcal vaccination rate for patients aged 65 and older was a dismal 16%.<sup>3</sup> This is far below the Healthy People 2000 goal of 60% to 80%.<sup>4</sup> In response to this information, we decided to undertake a performance-improvement initiative at our hospital-affiliated primary care teaching site, The Long Branch Community Health Center.

We first conducted a pilot study, the results of which have already been published,<sup>5</sup> to determine a baseline vaccination rate for the elderly patients seen at our health center. Our baseline vaccination rate was 32% (30 of 94 cases). Based on the fact that about two-thirds of our unvaccinated population in the

pilot study were either uninformed or unaware of the vaccine (another one-quarter refused vaccination),<sup>5</sup> we implemented a strategy targeting both patients and physicians for education about the pneumococcal vaccine. We supplemented this with a strategy of using standing orders for nurses to offer the pneumococcal vaccine at the time of influenza vaccine administration.

This article reports the effects of our interventions on our center's vaccination rate and compares the rates during phases of intervention strategies.

## METHODS

The study was conducted at the Long Branch Community Health



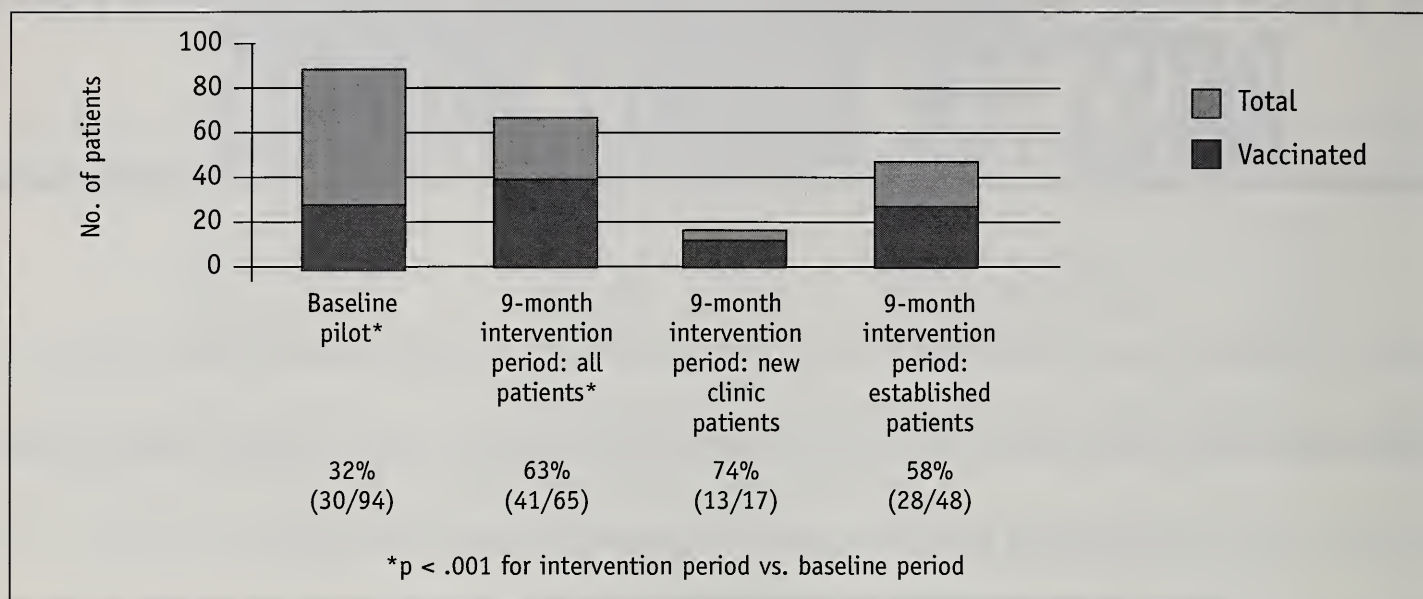


Figure 1 Baseline and nine-month intervention period results for pneumococcal vaccination of adults 65 and older seen at the health center

Center, a primary care center affiliated with Monmouth Medical Center. The center is located in the underserved area of Long Branch, where the attending and resident staff provide about 8,000 continuity-of-care visits annually.

Patients aged 65 and older who did not receive pneumococcal vaccines within the past five years and who visited the health center during the nine-month intervention period were included in this study. All other patients were excluded from analysis. The director of the Monmouth Medical Center Institutional Review Board waived formal review of our study.

The intervention period, planned to last nine months, had three phases. The first phase was planned to

last three months (from 7/1/98 through 9/30/98) and employed a strategy of patient and physician

**DURING THE EDUCATION  
PHASE, THE HEALTH  
CENTER'S MEDICAL  
DIRECTOR LECTURED THE  
INTERNAL MEDICINE  
DEPARTMENT RESIDENTS  
AND ATTENDING  
PHYSICIAN OUTPATIENT  
PRECEPTORS ABOUT THE  
PNEUMOCOCCAL VACCINE.**

education. During this phase, the health center's medical director lectured the internal medicine department residents ( $n=36$ ) and attending physician outpatient preceptors ( $n=6$ ) about the pneumococcal vaccine. He also posted reminders in the health center's physician documentation rooms about the indications for the vaccine. For patients, he posted fliers (in English and Spanish) based on materials mailed by the New Jersey PRO at the registration desk and throughout the waiting areas. Handouts were also placed throughout the waiting areas. The reminders, fliers, and handouts remained in these areas throughout the full nine-month intervention period.

The second phase was planned to last six months (from 10/1/98

through 3/31/99) and employed a strategy of standing orders for the nursing staff (RNs and LPNs) to offer and administer the pneumococcal vaccine whenever a physician ordered the influenza vaccine. Because of a national shortage of influenza vaccine, however, this phase lasted only two months (from 10/1/98 through 11/30/98). The third phase lasted for four months (from 12/1/98 through 3/31/99), during which time no further intervention strategies were added while prior educational materials and standing orders remained in place.

On April 1, 1999, billing records were used to generate a list of all patients aged 65 and older seen at

**THE SECOND PHASE  
EMPLOYED A STRATEGY OF  
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THE PNEUMOCOCCAL  
VACCINE WHENEVER A  
PHYSICIAN ORDERED THE  
INFLUENZA VACCINE.**

our health center during the intervention period. A single resident physician reviewed the charts for evidence of documentation of

pneumococcal vaccination as indicated by the presence of both a signed informed-consent form and a nurse's documentation of pneumococcal vaccine administration. Those patients who met inclusion criteria for analysis had their vaccination status recorded, as well as the dates of their visit to the health center.

After gathering the data, we performed chi-square analysis to determine whether there was a significant difference between the vaccination rate of the population seen during the nine-month intervention period and that of our pilot study. In a secondary analysis, we compared the rates for the three phases to deter-

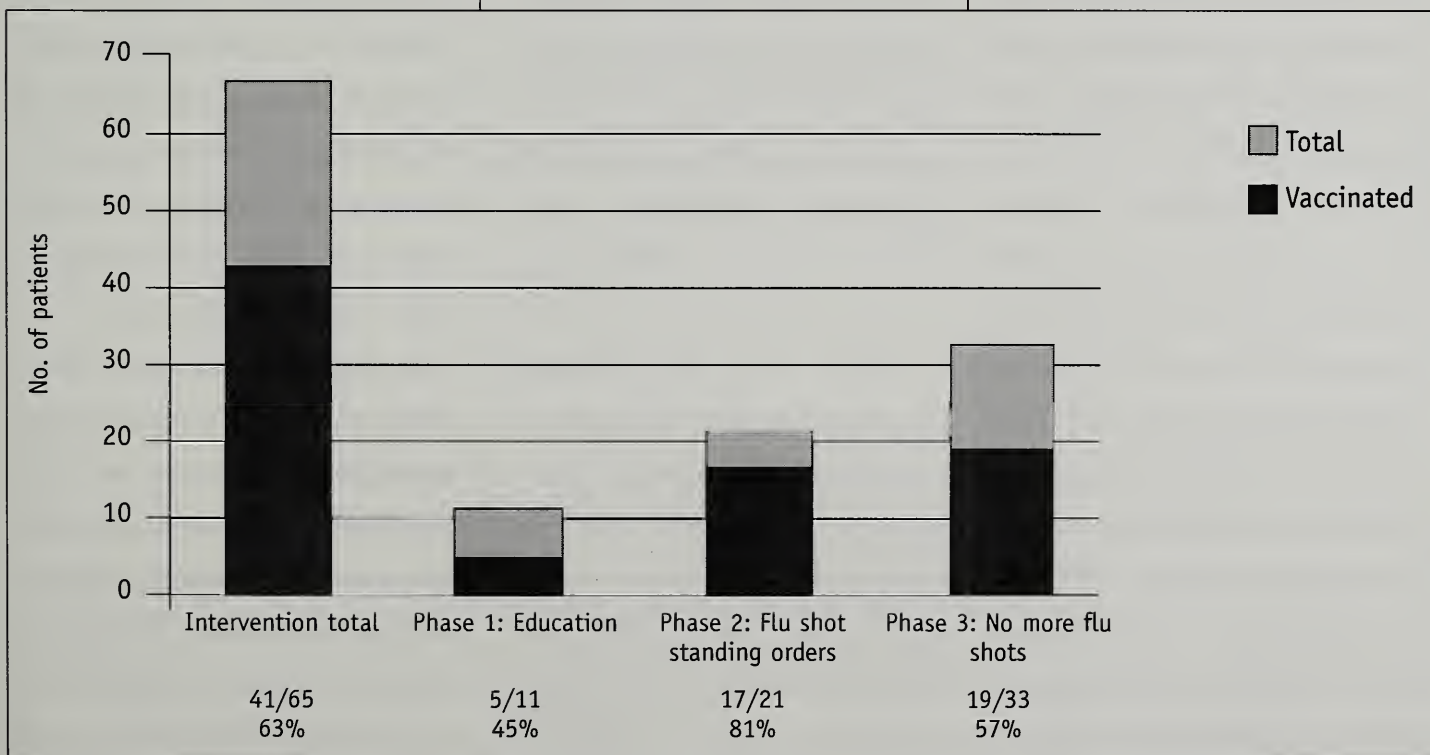


**Figure 2** Intervention period results for vaccinations given to patients age 65 and older broken down by strategic intervention time periods



mine trends in the successes of the separate intervention strategies.

## RESULTS

During the nine-month intervention period, we saw 65 previously unvaccinated patients aged 65 and older. Of these 65 patients, we administered 41 pneumococcal vaccinations, yielding a rate of 63% for the intervention period ( $p < .001$ ).

During the intervention period, we vaccinated 74% (13/17) of patients who were new to our facility and 58% (28/48) of our established patients who were previously unvaccinated (Figure 1).

In a secondary analysis, we sought to determine the rates for the separate phases during our nine months of follow-up. Four patients were seen during all three phases, and they refused vaccination each visit. These four patients were included only in the earliest time period for which they were seen, period one. Two patients who also consistently refused vaccination were each seen in phases two and three. These two people were included only in time-period two for analysis. The results are listed in Figure 2. The data from Figure 2 seems to show a trend in favor of standing orders charging the nursing staff to administer the pneumococcal and influenza vac-

cines simultaneously. A larger sample size would be needed for statistical significance. Of the 17 vaccines administered during the standing-order-intervention period, 12 occurred for patients where the physician only specifically ordered an influenza shot.

## DISCUSSION

This demonstration shows that interventions can be helpful in improving pneumococcal vaccination rates in a suburban New Jersey community health center's elderly patient population. Several interventions to improve rates have been proposed in the literature and by the New Jersey PRO.<sup>6</sup> These include patient posters and pamphlets, standing orders, performance feedback, medical chart reminder stickers, patient reminder postcards, and wallet-sized immunization cards. Schreiner studied the effects of simple chart reminders on house-staff compliance with preventive procedures and found that while there was a significant improvement in pneumococcal vaccination rates, the intervention only achieved a rate of 33%.<sup>7</sup> Given the budgetary constraints of serving an underserved population, we did not implement the patient reminder postcards and wallet-sized immunization cards

because of postage and personnel costs. Our health center's charts have a health maintenance sheet that already tracks this information.

The health center's medical director felt that the patient posters and brochures supplied by our PRO and manually produced with our desktop publishing software would be effective low-cost interventions. The strategy of physician education is already a part of our department and residency program's educational mission, and therefore we did not incur any extra cost related to lectures about pneumococcal vaccination. The same is true for the peer chart review and feedback process, which has been a normal part of our overall residency curriculum and health center quality improvement functions for the past 18 months. As for the standing orders, we expected that this policy change would not dramatically affect patient length of visit or increase nursing time.

The improved nine-month vaccination rate, to 63%, may have two areas of bias that seem to have contrary effects. With increased attention given to this problem, it is possible that there was a Hawthorne effect that helped to improve our rate. On the other hand, we had patients who were chronic refusers of vaccination. After vaccinating the

willing patients in our elderly population over the past few years, it is likely that the remaining population had a higher proportion of refusers. This is supported by the fact that our vaccination rate was higher in patients new to the center (74%) compared with our established patients (58%) seen during the intervention period.

This study seems to support that the use of standing orders had a greater impact than educational strategies alone, although analysis of this data is limited by the small sample size and the extension of the education phase into the other phases of the study. It is well-known that physician compliance with the influenza vaccine is better than with the pneumococcal vaccine.<sup>8,9</sup> Supporting the use of standing orders is the fact that, during the third phase, when influenza vaccine was no longer available, our pneumococcal vaccination rates decreased. The rate during this phase was lower than the rate when the flu vaccine was available but higher than the rate obtained before the use of standing orders. The findings show that standing orders for nurses to administer the pneumococcal vaccine at the time of influenza vaccination is a method of improving compliance rates and

## INTERVENTIONS CAN BE HELPFUL IN IMPROVING PNEUMOCOCCAL VACCINATION RATES IN A SUBURBAN NEW JERSEY COMMUNITY HEALTH CENTER'S ELDERLY PATIENT POPULATION.

should be encouraged. Preexisting standing orders for flu and pneumococcal vaccines should also be encouraged in ambulatory care settings.

*Todd Gruber is director of the Long Branch Health Center and assistant professor of medicine, MCP, at Hahnemann University School of Medicine, and Rao Marada is an internal medicine resident, PGY-II, at Monmouth Medical Center.*

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- Airborne Express

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- Plaintiffs
- Attorney General's Office
- Prosecutor's Office
- Municipal Court
- Superior Court

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# TEEN-FRIENDLY SERVICES

## ADVOCATES FOR SUCCESSFUL TEEN CONTRACEPTION

TEENAGERS SEEKING CONTRACEPTIVE ADVICE NEED TEEN-FRIENDLY SERVICES THAT ARE ACCESSIBLE, FREE OR LOW-COST, CONFIDENTIAL, AND CONVENIENT. FROM THE TEEN'S PERSPECTIVE, THE PICTURE IS QUITE SIMPLE: "I NEED HELP NOW, I DON'T WANT MY PARENTS TO KNOW ABOUT IT, I HAVE NO MONEY, AND I'M NOT SURE WHAT TO DO." IT IS THE RESPONSIBILITY OF THE CLINICAL STAFF TO WALK NEW PATIENTS THROUGH THE STEPS OF BECOMING A SUCCESSFUL HEALTH CARE CONSUMER, KEEPING IN MIND THAT THEY HAVE NEVER ACTED INDEPENDENTLY IN THIS AREA BEFORE.

*Bonnie L. Parker, RN*

There are more than one million teen pregnancies annually in the United States. Each year, publicly funded family planning programs prevent some 256,000 unintended teen pregnancies. As a group, teens are more likely than older women to rely on public clinics for contraceptive services.<sup>1</sup> However, according to the Alan Guttmacher Institute, only an estimated 39% of all US teens in need of services currently receive the contraceptive care they need. NJ ranks 42nd in adequate provision of public family planning services to women in need. While 102 publicly supported family planning clinics in New Jersey serve 37,280 teenagers, this represents only 26% of teenagers in need.<sup>2</sup>

Sexually active teens who want to prevent unintended pregnancy must use a method of contraception. To be effective contraceptive users, they must have:

- Motivation to prevent pregnancy and to use contraception effectively and consistently.
- Basic knowledge about available methods.
- Support in using a method, particularly from a partner.
- Financial access to the method chosen.
- Skills to use the method correctly.

Finally, teens must actually have the contraceptive they have chosen to use—implants must have been implanted, pills must be in her possession, or the condoms in his pocket or her purse.<sup>3</sup>

An effective clinician must take extra time to ensure understanding of the information provided. This is key to compliance. We cannot assume teens hear what they think we are telling them or that the information is as useful as we think it is. According to Claire Brindis, Dr. PH, at the University of California-

San Francisco, clinical counselors in some settings review the minimum information for a particular contraceptive method, such as general use, side effects, and health risks, but may not discuss all of the details that are crucial to ensuring commitment and compliance. For example, consistent use of condoms or withdrawal requires a young person to have the skills to communicate and negotiate with a sexual partner; yet counselors rarely have the time or programmatic support to teach such skills.<sup>4</sup> Dr. Brindis also cites a survey by the American Academy of Pediatrics that determined that only 34% of surveyed physicians routinely asked their patients, when appropriate, about family planning. Pediatricians, nurse practitioners, and advance practice nurses are the health care professionals who demonstrate greater involvement in contraceptive care.<sup>5</sup>



## THE HiTOPS PROGRAM

At HiTOPS, our mission is to promote adolescent health and well-being. Our goals are to promote rights, respect, and responsibility for and among teens regarding healthy sexual relationships, decreased teen pregnancy, and sexually transmitted infections. Educational programs include peer-led initiatives as well as staff outreach in schools throughout NJ. Clinical services include gynecological exams, contraceptive services, testing for pregnancy and sexually transmitted infections (STI), and counseling, treatment, or referral for both. Our model of combining education with reproductive health services has been noted by the World Health Organization as "successful and replicable," and our collaboration with the NJ Departments of Health and Senior Services and Human Services has allowed us to influence educational strategies in schools throughout NJ.

HiTOPS opened in 1988 as an offshoot of Familyborn Birth and Women's Health Center. We wanted to prevent some of the teen pregnancies we were seeing in increasing numbers. With a community advisory board composed of parents, health care professionals, and teens, we established a need and guidelines for services. A substantial grant allowed us to develop a musical production depicting current issues teens were facing. These talented, passionate young amateurs took "HiTOPS in Wonderland" to six area schools to announce that the

| Referral Source                           | Percentage of Points |
|-------------------------------------------|----------------------|
| Word-of-mouth from friends and classmates | 50%                  |
| Education outreach                        | 15%                  |
| Parents                                   | 12%                  |
| School nurses, counselors, and therapists | 10%                  |
| School newspaper ads                      | 8%                   |
| Yellow Pages                              | 4%                   |
| Pediatricians and other physicians        | 1%                   |

**Table 1. Breakdown of Patient Referrals to HiTOPS**

HiTOPS teen health center was opening in Princeton. Our first year we had 37 clients; all came because they thought they were pregnant or had symptoms of sexually transmitted infections.

Our staff of eight consists of one male educator and seven female

clinicians (two CNMs and three RNs), educators, and administrators. The CNMs provide most of the clinical care for the young women. A male perspective is important for education outreach as well as to counsel young men in the clinic regarding responsibility and risk reduction. We are planning more clinical services for males in the near future.

HiTOPS provides reproductive health care for 500 to 600 young women a year between the ages of 11 and 24. In addition, we provide contraceptive counseling and condoms to about 100 young men each year. Because of NJ practice standards for CNMs, we currently refer young men to area STD clinics for testing and treatment.

Teens find their way to HiTOPS in a variety of ways (see Table 1). It is surprising to us that more referrals aren't made by pediatricians or other physicians, but many of our teen clients say they are not comfortable discussing sexual health issues with their regular care

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providers. Physicians themselves may be uncomfortable with such discussions because of a long relationship with the child's parent(s), because they have teens of their own, or because of cultural values or poor preparation in medical school; these factors may affect how they respond to a sexually active teenager seeking contraception or STD testing. Mixed messages regarding sex and sexuality throughout our culture may further foil useful discussion between patient and provider. If allowing teens to continue reproductive health services confidentially with the current provider is not an option, transferring this aspect of care to a sensitive clinician, gynecologist, or teen health center is an effective solution. The goal is to help teens develop practices that ensure responsible, healthy lifestyles. They are more likely to do so if they interact with friendly, understanding care providers who involve them in the process.

Teen-friendly services are confidential, free or affordable, easily accessible (including after school, evenings, Saturdays, and walk-in appointments), conveniently located, and nonjudgmental. All staff should be advocates for teens, helping them to become responsible health care consumers. Questions should be answered honestly—scare tactics are not useful to teens.

Last year HiTOPS began mailing a Clinical Update Bulletin to area pediatricians, OB/GYNs, school nurses, counselors, and other youth-serving health agencies to

**ONLY 34% OF SURVEYED  
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keep providers aware of the newest strategies for adolescent reproductive health and risk reduction. Topics include information on emergency contraceptive pills (ECPs), tips for identifying teens involved in high-risk sexual behavior, and strategies to help teens develop skills for responsible sexual decision-making.

The majority of our clients call or come in to make an appointment to begin contraception because they are or are about to become sexually active. Oral contraceptives (OCs) are the method of choice for most teens. Missed pills and resultant breakthrough bleeding are not uncommon complaints within the first three to six months of use. We recommend Depo-Provera as the best method for younger teens, given their inexperience and difficulty with compliance. With the increased awareness of and requests for emergency contraceptive pills (ECPs) we are moving more girls directly from ECPs onto OCs. Condoms are heavily promoted and given free to males and females with strong messages that 1) both partners

need their own method of protection every time, 2) no method is 100% risk-free, and 3) condoms are the best method for preventing sexually transmitted infections. Proper use is demonstrated. Lubricants are promoted to help prevent condom breakage. Teens are brought back at two and six months to monitor compliance as well as to discuss client concerns. This provides an excellent opportunity for reinforcing the advocacy to use both condoms and pills.

Twenty-five percent of clients make the initial visit for STI or pregnancy testing. We routinely test for STIs when there is reason to believe a young woman has engaged in risky behavior or has been exposed. Last year, 54% of all clients were tested for STI; 10% tested positive for chlamydia, gonorrhea, HPV, herpes, or syphilis. HIV testing is offered on site and referrals are made to an off-site center for free, anonymous testing. In addition, we gave ECPs 73 times to 63 clients. Most clients who present initially for pregnancy or STI testing or for ECPs return for full gynecological services. In general, our return rate is quite high (67%).

The initial gynecological visit usually lasts one hour. After filling out intake and medical history forms, as well as a health and concerns form, the CNM reviews the paperwork before inviting the patient into her office. We always ask for phone numbers and addresses where we can contact the client without jeopardizing confidentiality. We



often need to reassure them repeatedly that their chart is confidential and that we cannot by law divulge any information without their written permission.

Because focus groups have told us teens avoid accessing health care facilities and obtaining contraception due to fear of a pelvic exam and mountains of forms, we allow paperwork to be streamlined and spread out over several visits. The history, presenting symptoms, and probing discussion often provide enough information to determine whether the client can be given contraception without a pelvic exam on the first visit. If harm reduction is the goal, no sexually active teen should leave the office without pills or Depo and condoms—and a sense of accomplishment and pride for being a responsible health care consumer.

Seventy-five percent of our clients do not want their parents to know of their visit to HiTOPS. While it is likely that many of these parents would be pleased to know their children are acting responsibly, we never know which ones. Over the past 11 years we have had a handful of angry parents storm into the center wanting to sue us for treating their daughters without parental permission. Often empathetic, sensitive conversation helps them calm down and realize the alternatives could be worse. Bringing the parents in to talk with staff and the client—with the client's consent—has often led to better understanding and communication.

Many of our clients don't have the money to pay for services. They are not turned away. We do not submit to insurance for confidentiality purposes. We will issue a bill for insurance reimbursement to teens if they or their parents request one. We make sure our clients know that money should not be an obstacle to returning for another visit or to obtaining contraception. We allow teens to run a tab. Teens often ask friends to help pay, comb their cars for loose change, or pay off their bill over the years. We encourage males to share their partner's costs. And many of our clients just get free, top-quality care and we write it off as a loss. That number is growing each

IF ALLOWING TEENS TO  
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HEALTH CENTER  
CLINICIAN IS AN  
EFFECTIVE SOLUTION.

year as more low-income teens access our services than in the past.

Having established a good relationship with HiTOPS, many teens continue with us through college or after they enter the workforce, at which point we help them make the transition to the adult world of health care.

Bonnie L. Parker, RN, is executive director of HiTOPS, Inc. For more information about this and other HiTOPS programs, please visit <http://www.princetonol.com/groups/hitops>.

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# COMMUNICATING WITH PATIENTS WHO HAVE HEARING LOSS

ACCESS TO HEALTH CARE SERVICES IS OF PARAMOUNT INTEREST TO ALL NEW JERSEYANS. FOR PEOPLE WITH VARYING DEGREES OF HEARING LOSS, AFFORDABLE HEALTH INSURANCE, WHILE IMPORTANT, IS NOT THE ONLY BARRIER TO QUALITY HEALTH CARE. DOCTORS ARE REQUIRED BY LAW TO ENSURE EFFECTIVE COMMUNICATION BETWEEN THEMSELVES AND THEIR DEAF OR HARD-OF-HEARING PATIENTS.

*Richard Herring  
Ira Hock*

For a patient who is deaf or hard of hearing, visits to the doctor or hospital are tantamount to an American traveler who does not speak the local language and is in need of medical care in a foreign country. Imagine the medical fate of this traveler when attempting to communicate in English with a doctor who speaks only Russian or who had only a few English classes. The traveler may describe medical history, allergies to medications, and symptomatology in minute detail, only to hear back

from the doctor an abbreviated, elementary version of the description, perhaps with critical parts omitted.

Unlike a traveler, a deaf person's anxiety is not limited to a two-week excursion but can exist for a lifetime. For many deaf persons, accessing medical care is so frustrating that they simply give up. For example, patients sometimes think they are seriously ill when in reality the ailment is relatively minor. Many delay appointments or avoid going to the doctor at all because of communication problems.

## THE LAW

Title III of the Americans with Disabilities Act (ADA) attempts to remedy the communication barrier between deaf Americans and medical services. ADA regulations stipulate that medical service providers are required to make services accessible by taking appropriate measures to ensure "effective communication" for both patients and guardians of patients who are deaf or hard of hearing. The ADA, enacted in 1990, bolstered the rights of people with disabilities to access goods



and services on as equal a basis as those without disabilities.

Title III of the ADA in part prohibits discrimination against people who are deaf or hard of hearing in places of public accommodation. Public accommodations include professional offices of health care providers regardless of the size of the office or number of employees.

Like the installation of ramps and the removal of other architectural barriers for physically challenged people, communication barriers to services must be broken down for people with hearing loss. There are several ways to provide reasonable accommodations depending on the communication needs of the individual.

## DOCTOR/PATIENT COMMUNICATION

There are several auxiliary aids that may facilitate what the ADA mandates as effective communication. A qualified sign-language interpreter will bridge the communication barrier between English-speaking health care providers and patients or guardians who use American Sign Language (ASL) as their primary mode of communication. Other aids include assistive listening devices that are needed by many people who are hard of hearing or real-time captioning, which

may be preferred by people who are postlingually deafened.

The ADA stipulates that the public or private entity must look to the person with hearing loss when deciding which accommodation to provide. For example, a patient may indicate that writing notes back and forth is ineffective and not an appropriate accommodation. This is often true when the primary mode of communication is American Sign Language and not English.

English may be a deaf person's second language and ineffective for the majority of significant communication transactions. It is thought that many native-born, deaf ASL users read English at a fourth- to

fifth-grade level. This is not to say that an American deaf individual is illiterate, simply that English is at best a second language. Lipreading is also not an option for a native ASL user. Studies show that even the best lip-readers achieve only 30% accuracy, because of differing articulation and phonetic styles. In cases involving a deaf ASL user, health care providers should have a qualified professional sign-language interpreter available. Health care can be compromised if interpreters are not provided when appropriate.

## WHO IS A QUALIFIED INTERPRETER?

The ADA defines a qualified interpreter as someone who can "interpret effectively, accurately, and impartially both receptively and expressively, using any necessary specialized vocabulary."

A professional sign-language interpreter is a person who has received years of specialized formal training to facilitate communication between deaf and hearing individuals. One common misconception is the assumption that a basic course in sign language, the ability to finger spell, or having a deaf family member or friend is a sufficient criterion to qualify someone as an interpreter for the deaf. As well-meaning as their intentions may be, sign-lan-

LIKE THE INSTALLATION  
OF RAMPS AND THE  
REMOVAL OF OTHER  
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FOR PHYSICALLY  
CHALLENGED PEOPLE,  
COMMUNICATION  
BARRIERS TO SERVICES  
MUST BE BROKEN DOWN  
FOR PEOPLE WITH  
HEARING LOSS.

## FOR MORE INFORMATION

### New Jersey Department of Human Services

#### New Jersey Division of the Deaf and Hard of Hearing

The division is the primary contact agency in New Jersey for information and referral on topics relating to hearing loss. In this role, division staff responded to approximately 2,535 requests for information related to hearing loss during a recent year.

In addition, the division publishes the *Monthly Communicator* newsletter, which is mailed to more than 6,400 deaf and hard-of-hearing individuals and professionals serving people with hearing loss. The newsletter is a major source of information for the deaf and hard-of-hearing community and includes information about cultural, social, education, and employment activities.

The division also provides the following publications, among others:

"Organizations Serving People with Hearing Loss in New Jersey"

"Interpreters and the Deaf Community"

"Computer-aided real-time translation lists of reporters"

Contact:

New Jersey Division of Deaf and Hard of Hearing

PO Box 074

Trenton NJ 08625

(609) 984-7281 V/TTY

<http://www.state.nj.us/humanservices/dhsddhh1.html>

#### Registry of Interpreters for the Deaf

Registry for the Interpreters for the Deaf (RID) provides:

- Training for new and professional interpreters through the professional development committee and the certification maintenance program.
- Continued certification through RID's national testing system.
- Self-regulation through a national ethical practices system.

In addition to originating and administering the national testing system that certifies interpreters, RID also provides various support services to practicing interpreters, students of interpretation, and persons who share an interest in the field of interpretation. Information about speakers, workshops, and classes are offered for the ADA and the interpreting profession, among many others.

Contact:

RID, Inc.

8630 Fenton St.

Suite 324

Silver Spring MD 20910

(301) 608-0050 V/TTY

(301) 608-0508 fax

<http://www.rid.org>

guage students, educators of deaf children, relatives and friends of deaf people, or nurses who might know some sign language are not qualified interpreters.

Formal academic training alone is not enough to qualify one as a professional interpreter. The same is true in many other professions, in which simply attending a professional academic institution and passing all necessary course work does not automatically grant a license to practice the profession. The ability to interpret is a skill separate from sign language proficiency itself, and a person who is conversant in ASL does not necessarily possess the skill and expertise to effectively function as a professional interpreter.

Health care professionals should always ask prospective interpreters for their credentials. If they have passed the New Jersey Division of the Deaf and Hard of Hearing's screening test, they will have a copy of a letter indicating so. Certified interpreters also should produce their membership card from the Registry of Interpreters for the Deaf. Providers may contact the New Jersey Division of the Deaf and Hard of Hearing to ascertain whether or not an interpreter has these credentials.



## REASONABLE EFFORTS

Since the demand for professional sign language interpreters exceeds the supply, they should be scheduled weeks before an appointment, when possible. In emergency situations, reasonable attempts to secure the services of a qualified interpreter must also be made. The Division of the Deaf and Hard of Hearing can be contacted directly for an interpreter Monday through Friday from 9:00 AM to 5:00 PM by calling (609) 984-7283. For nonbusiness hours, the division disseminates lists and phone numbers of qualified interpreters in addition to other referral services.

## FINANCIAL CONSIDERATIONS

While individuals with hearing loss contend that they are often the victims of a discriminatory health care system, many medical practitioners feel that these accommodations impose an undue financial burden. Like the installation of access ramps where required, communication access provisions do incur some expense. The cost, to be borne by the health care provider, is a fee that must be negotiated directly with the interpreter. Most interpreters charge between \$30 and \$50 per hour with a two-hour minimum. Therefore, a 15-minute

treatment will average \$100 with travel expenses. The ADA also states that this cost may not be charged to the patient directly or indirectly. Most insurance companies to date do not reimburse for this expenditure, nor do federal statutes require them to do so.

While this arrangement may seem unreasonable to many physicians, most of them are not likely to see many deaf patients in a given year. In the event that a health care provider does have many deaf patients, there is an "undue burden" clause that protects places of public

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accommodations. Pursuant to ADA, 28 CFR 36.104 and DOJ Analysis at 56 CFR 35709, the entity must consider its overall budget to determine whether or not the payment for the accommodation is an undue burden. For example, paying an interpreter \$100 twice a year is hardly a burden for a doctor, but paying for an interpreter several times a week may be.

The costs of not providing the interpreter, however, can often be greater to the doctor and the industry in the long run than the costs of providing the required accommodation. Deaf patients often must make repeated visits to their doctors because they did not understand or cannot follow recommendations. In addition, many deaf patients who misunderstood therapeutic directions end up in the emergency room for treatment, compelling the hospital to hire and pay for interpreting services and the insurance carrier to pay hospital rates for medical services that might have been treatable during ordinary office visits.

According to a National Association of the Deaf Law Center handout titled *Title III Provision of Auxiliary Aids*, "the cost of interpreters and other auxiliary aids may entitle a business to an income tax credit as

well as the usual business-related expense deduction." Congress has amended the Internal Revenue Code to provide business tax incentives for removing barriers or increasing accessibility. The "Tax Deduction to Remove Architectural and Transportation Barriers to People with Disabilities and Elderly Individuals" (9 Title 26, IRC Section 190) allows a deduction for qualified barrier-removal expenses not to exceed \$1,500 for any taxable year. (The provision of a sign-language interpreter removes the communication barrier by facilitating communication between a person who is deaf and signs and a hearing person who does not use sign language.)

The "Disabled Access Tax Credit" (Title 26, IRC Section 44) is available to eligible small businesses. For more information about these tax provisions, contact the IRS, Office of the Chief Counsel, PO Box 7604, Ben Franklin Station, Washington DC 20044, (800) 829-1040.

Lawsuits have been filed against at least seven New Jersey hospitals in the past year alone. Thus far, three have reached settlement agreements. In the largest case of its kind across the nation, one NJ hospital agreed

## HEALTH CARE CAN BE COMPROMISED IF INTERPRETERS ARE NOT PROVIDED WHEN APPROPRIATE.

to pay \$700,000 to four deaf New Jersey residents for its failure to provide interpreters, closed captioning, and telecommunications devices on hundreds of occasions over a 10-year period.

### HIRING ALTERNATIVES

Some health care providers may turn to telemedicine systems adapted for video remote interpreting (VRI) to serve deaf clients. VRI is a system by which interpretation services at a remote location, usually an interpreter referral service, is transmitted via video camera, ISDN telecommunications lines, and a receiving monitor in the doctor's office. Other health care provider groups have cooperatively hired a staff interpreter as a more cost-effective and creative approach to ensuring that all parties' needs are met.

*Richard Herring joined the New Jersey Division of the Deaf and Hard of Hearing in*

*early 1981 as a field representative. In 1982 he was chosen to be the division director and as such is responsible for managing the daily operations of all programs and services, supervising DDHH employees, responding to the Advisory Council on the Deaf and Hard of Hearing, and collaborating with the Department of Human Services on financial and legislative issues. He initiated the division's annual Deaf and Hard of Hearing Awareness Day at Six Flags Great Adventure theme park in Jackson NJ in 1984 and the division's Speaker's Bureau to provide the community with resources for training opportunities relating to hearing loss sensitivity. He earned a bachelor's degree in business management from Fairleigh Dickinson University; previously he was involved in importing, exporting, and manufacturing with Hermann Weber & Co., Inc. and R. Herring Associates in New York, New Jersey, and California.*

*DDHH executive assistant Ira Hock has a bachelor's degree in social work and began working for the Department of Human Services 1979 as a caseworker in the Division of Youth and Family Services. In 1982 he transferred to the Commissioner's Office as assistant chief, bureau of client services advocating on behalf of clients with developmental disabilities and mental illness. In 1990 he was transferred to the Division of the Deaf and Hard of Hearing, where his responsibilities include fiscal management, administration of the TTY distribution program, advocacy and serving as editor of the Monthly Communicator newsletter.*



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**T. Rowe Price New Jersey Tax-Free Bond Fund** (NJTFX) ranked #2 out of 15 funds in the Lipper New Jersey Municipal Debt Category since its inception (4/30/91) for the period ending 9/30/99.\* This fund invests primarily in long-term New Jersey municipal securities, so the income it offers is double-tax-free. *You pay no state or federal tax on your investment earnings.\*\** Proprietary credit analysis and active management help reduce risk. Of course, the fund's yield and share price will fluctuate as interest rates change.

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**-2.71%, 6.11%, and 6.72%** are the fund's 1-year, 5-year, and since inception (4/30/91) average annual total returns, respectively, for the periods ended 9/30/99. Figures include changes in principal value, reinvested dividends, and capital gain distributions. Investment return and principal value will vary, and shares may be worth more or less at redemption than at original purchase. \*According to Lipper Inc., which ranked T. Rowe Price New Jersey Tax-Free Bond Fund #34 out of 52 for the 1-year period ended 9/30/99. \*\*Some income may be subject to the federal alternative minimum tax. Income earned by non-New Jersey residents will be subject to applicable state and local taxes. †\$500 minimum. Past performance cannot guarantee future results.

For more information, including fees and expenses, read the prospectus carefully before investing. T. Rowe Price Investment Services, Inc., Distributor.

NJB052719

# GOOD NEWS FROM THE AMA

THE AMA IS ON THE MOVE! THIS HAS BEEN A HIGHLY SUCCESSFUL YEAR FOR STRENGTHENING THE AMA'S STATURE IN THE EYES OF THE MEDICAL PROFESSION AND THE GENERAL PUBLIC. MUCH OF OUR SUCCESS CAN BE ATTRIBUTED TO A HIGHLY ENERGIZED GRASSROOTS INVOLVEMENT, WHICH MOST DESERVEDLY IS DRAWING FAVORABLE REVIEWS NOT ONLY FROM OUR MEMBERS AND THEIR PATIENTS BUT ALSO FROM INFLUENTIAL ELEMENTS OF THE NEWS MEDIA.

*Joseph A. Riggs, MD*

There is much good news to report for the year 1999.

**Membership.** For the first time in several years, we will end up with more members than before we started. The AMA surpassed its 1999 membership goal of 291,000 and by year-end we should end up with approximately 293,000 members. Our new goal for the year 2000 is 300,000 members.

**Patients' Bill of Rights.** The AMA exercised its political clout in Washington and influenced passage of the Norwood-Dingell Bill in the House, allowing patients to have a choice and a voice in their health care. This was the most publicized bill in 1999, and it became the AMA's most influential victory in the past 20 years.

**AMA Lawsuit.** The AMA filed a lawsuit against Donna Shalala, secretary of Health and Human Services (HHS), who refuses to cor-

rect errors made by the Health Care Financing Administration (HCFA) regarding the sustainable growth rate (SGR), causing a \$3 billion underpayment to physicians. In the meantime, however, for the year 2000, physicians will receive a 5.4% payment increase in the Medicare physician payment formula. This represents the biggest across-the-board increase in Medicare payment rates since resource-based relative value scale (RBRVS) began in 1992.

**Antitrust Relief.** The AMA is leveling the playing field between physicians and their health care plans. The AMA is openly and aggressively supporting the Campbell-Konyers Bill, which calls for an exemption from present antitrust laws, thus allowing physicians the right to collectively bargain.

**Physicians for Responsible Negotiation (PRN).** In the meantime, the AMA has created an indepen-

dent, national negotiating organization that will give a collective voice to physicians' concerns. At present, the PRN can represent only employed physicians, residents, and students. The PRN is not a typical labor union, in that physicians will not be able to strike or endanger patient care.

**Health Sector Assembly (HSA).** The AMA gathered more than 50 organizations—including leaders of many state and specialty societies, health care professionals, academicians, and government, business, and insurance industry representatives—to discuss providing health insurance to all Americans. The AMA will not rest until all Americans receive proper health care.

**Is It Good Medicine?** The AMA theme for the year of 2000 is "Is it Good Medicine? A Time to Lead—A Challenge to Serve." We plan to use advertorials in national newspapers



and journals about public health issues, keeping in mind that whatever is discussed, it ultimately comes down to the final question, "Is it good medicine?"

**New JAMA Editor.** The AMA has named Katherine D. DeAngelis, MD, as new editor of *JAMA*; she is committed to maintaining *JAMA*'s standards of editorial excellence in the 21st century.

**AMA Online.** The AMA has formulated a program that will allow for digital credentials to help physicians authenticate their identities online. There is much concern about privacy and confidentiality of medical records on the Internet. This program will ensure that medical records will be released only to designated and credentialed individuals.

**Medem.com.** Accurate and helpful communication is becoming the top contention for patients in selecting and keeping their personal physician. The AMA has joined with six other specialty societies in a new Web site enterprise called Medem.com. This Web site offers the most credible, trustworthy, and quality health information on the Internet.

## For the Year 2000

**AMAP.** Approximately four years ago, the AMA committed to the highest professional standards for medical and physician accreditation. It launched the American Medical Accreditation Program as a major element of its strategic vision of being an acknowledged leader in promoting professionalism in med-

icine and setting standards for medical practice.

In November 1999, the AMA retained the MEDSTAT group to enhance the effectiveness and value of AMAP. MEDSTAT will work with the AMA to lower AMAP operating costs, evaluate emerging market needs and opportunities, and promote improved services through existing and future AMAP contingencies. New Jersey was the first state to form a partnership with AMAP, and very few changes will be made to the MRAC program in New Jersey.

**Health Access.** The hot topic in the year 2000 is access to health care for all Americans. The AMA expects to set the agenda for the ongoing national debate over health care and define the health care issues for all candidates, especially getting them to commit to access to health insurance. In the process, the AMA will be the national leader for health system reform and what's in the best interest of physicians and their patients.

THE AMA WILL  
NOT REST  
UNTIL ALL AMERICANS  
RECEIVE PROPER  
HEALTH CARE.

## AMA'S National House-Call 2000.

Our tactical plan is to take our leadership and issues on the road, traveling to the key primary states from January to election day 2000. We will have a mobile campaign headquarters, consisting of two vans emblazoned with the AMA's logo and "Is It Good Medicine?" The AMA will be present in the national media spotlight at the mayors', governors', and Republican and Democratic conventions and forums all over the country. We are going on the road to campaign on the issues that matter most to patients and the health of this country: patients' rights, universal coverage, physician negotiations, Medicare reform, and patient and record confidentiality. We will also be addressing such public health issues as the role of women in health care decision making, tobacco and alcohol abuse, obesity, violence, and end-of-life care. We plan to ensure that all presidential and congressional candidates debate our issues and address our concerns.

These are all challenging endeavors, and the AMA is the only organization that has the stature, the credibility, and the momentum to take them on. With careful planning, strategic execution, close adherence to "Is it good medicine?" principles, and unstinting perseverance to drive the effort to a favorable conclusion, the AMA will have a maximum impact on health care in this country this year.

*Joseph A. Riggs is a member of the board of trustees of the AMA.*



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☞This program is offered at convenient locations throughout the year in New York City, on the Cornell campus in Ithaca, in the San Francisco Bay Area, and at two sites in the Los Angeles basin.

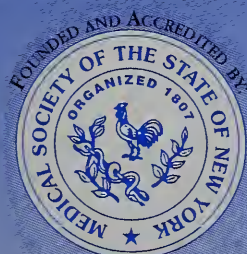
☞Upon completion of the four independent one-week modules, participants will receive

an Executive Certificate in Healthcare Delivery Management from the schools.

☞CME Accreditation/AMA Category 1 Credit This activity has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the Medical Society of the State of New York (MSSNY), The Johnson Graduate School of Management at Cornell University, and the Anderson Graduate School of Management at UCLA. MSSNY is accredited by ACCME to provide continuing medical education for physicians and takes responsibility for the content, quality and scientific integrity of this CME activity.

MSSNY designates this continuing medical education activity for a maximum of 30 hours per week of Category 1 credit toward the AMA/PRA (Physician's Recognition Award). Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

This credit may also be applied to the Medical Society of New Jersey Physician's Recognition Award.



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## THE AMNJ 2000 AWARDS

The Academy of Medicine of New Jersey has announced its awards for 2000. The 2000 Edward J. Ill award, presented to that physician of New Jersey who merits recognition for distinguished service as a leader in the medical profession and the community at large, will be presented to Joseph Fennelly, MD, of Madison. Dr. Fennelly is immediate past chairman of the Bio-Ethics Committee of MSNJ and serves as a member of the New Jersey Bioethics Commission. The 2000 President's Medical Educator Award will be presented to Rue V. Lourenco, MD, of Newark. Dr. Lourenco has served as dean of the UMDNJ-New Jersey Medical School for the past 10 years and will be retiring in June. The 2000 Citizen's Award will be presented to Lester Z. Lieberman, and the 2000 Medical Executive Award will be presented to John P. Ferguson.

## PRESIDENTIAL CANDIDATES ON THE UNINSURED

Three leading presidential candidates—former Sen. Bill Bradley, Vice President Al Gore, and Sen. John McCain—have issued statements recognizing a lack of health insurance as a serious health risk warranting as great a level of concern as such other health hazards as smoking, alcohol abuse, and not wearing a seatbelt. The statements were made in response to a new report issued by the American College of Physicians-American Society of Internal Medicine.

## ASTHMA ANSWERS FOR PATIENTS

The Asthma and Allergy Foundation of America announced the availability of its new *Asthma and Allergy Answers: Patient Education Library*, which provides medically accurate

answers to frequently asked questions on these topics. The book is available for \$50 plus shipping and handling. For more information, call (800) 7-ASTHMA.

## ONLINE CODING AND ASSESSMENT TRAINING SOLUTIONS

The American Health Information Management Association (AHIMA) has developed a Web-based coding assessment and training program designed to ensure that coders have the skills necessary to meet changing coding requirements and regulations. The program, Coding Assessment and Training

Solutions, includes a tool for assessing coders' skills and identifying areas requiring improvement. The training program covers ICD-9-CM and CPT coding systems. For more information, contact Jack Segal, (312) 233-1160 or [jsegal@ahima.org](mailto:jsegal@ahima.org).

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## NJ AUTHORS/NJ SUBJECTS: RECENTLY PUBLISHED

Nicholas A. Ashford and Claudia S. Miller, *Chemical Exposures: Low Levels and High Stakes*, 1999. (New York: John Wiley & Sons, Inc.) Based on a report commissioned by the New Jersey Department of Health.

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Garth H. Ballantyne, MD, FACS, FASCRS, professor of surgery, University of Medicine & Dentistry of New Jersey, Hackensack NJ. *Atlas of Laparoscopic Surgery*, 2000. (Philadelphia: W.B. Saunders, Inc.)

A. John Camm, MD, and Sanjeev Saksena, MD, FACC, Cardiac Medicine and Electrophysiology, Millburn NJ. *Electrophysiological Disorders of the Heart*, 2000. (Philadelphia: W.B. Saunders, Inc.)

# A L E N D A

**E V E N T**

**D A T E**

**L O C A T I O N**

**F e b r u a r y**

|                                           |                      |                                                    |
|-------------------------------------------|----------------------|----------------------------------------------------|
| <b>Tuberculosis Control</b>               | February 23, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911 |
| <b>Trauma Care for the New Millennium</b> | February 24-26, 2000 | Atlantic City Convention Center, (609) 441-8023    |

**M a r c h**

|                                                                     |                   |                                                                               |
|---------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------|
| <b>Clinical Cancer Research</b>                                     | March 1, 2000     | The Manor, West Orange, AMNJ, (609) 275-1911                                  |
| <b>Sleep Apnea Syndrome</b>                                         | March 1, 2000     | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Treatment of Chronic Bronchitis</b>                              | March 1, 2000     | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>International Conference on Advances in Cancer Immunotherapy</b> | March 2-4, 2000   | Princeton, (973) 844-7007                                                     |
| <b>Lumbar Disc Disease</b>                                          | March 8, 2000     | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Review of Physical Medicine and Rehabilitation</b>               | March 10, 2000    | Sheraton Tara, Parsippany, AMNJ, (609) 275-1911                               |
| <b>Juvenile Onset Diabetes</b>                                      | March 15, 2000    | St. Mary's Hospital, Passaic, (609) 275-1911                                  |
| <b>Imaging of Bowel Obstruction</b>                                 | March 16, 2000    | Cooper Health System, Camden, AMNJ, (609) 275-1911                            |
| <b>Clinical Infectious Disease 2000</b>                             | March 17-19, 2000 | New York City, Center for Bio-Medical Communication, (201) 342-5300           |
| <b>Nephrology Society Meeting</b>                                   | March 21, 2000    | UMDNJ-Robert Wood Johnson Medical School, New Brunswick, AMNJ, (609) 275-1911 |
| <b>Post-Polio Syndrome</b>                                          | March 22, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>NJ State Society of Anesthesiologists</b>                        | March 24, 2000    | Trump Plaza Hotel & Casino, Atlantic City, (609) 275-1911                     |
| <b>Travel-Related Illness</b>                                       | March 29, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Vascular Society of New Jersey</b>                               | March 29, 2000    | Morristown Memorial Hospital, AMNJ, (609) 275-1911                            |



**E V E N T****D A T E****L O C A T I O N****A p r i l**

|                                              |                   |                                                                               |
|----------------------------------------------|-------------------|-------------------------------------------------------------------------------|
| <b>Medical Problems in the Elderly</b>       | April 5, 2000     | St. Mary's Hospital, Passaic, (609) 275-1911                                  |
| <b>NJ Orthopaedic Society Annual Meeting</b> | April 8, 2000     | Caesar Park Penha, Subra, Portugal, AMNJ, (609) 275-1911                      |
| <b>Hepatitis</b>                             | April 12, 2000    | St. Mary's Hospital, Passaic, AMNJ (609) 275-1911                             |
| <b>American Surgical Association</b>         | April 13-15, 2000 | Philadelphia Marriott Hotel, (978) 526-8330                                   |
| <b>Nephrology Society Meeting</b>            | April 18, 2000    | UMDNJ-Robert Wood Johnson Medical School, New Brunswick, AMNJ, (609) 275-1911 |
| <b>Peripheral Vascular Disease</b>           | April 19, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Polymyalgia Rheumatica</b>                | April 26, 2000    | St. Mary's Hospital, Passaic, (609) 275-1911                                  |

**M a y**

|                                                      |                 |                                                              |
|------------------------------------------------------|-----------------|--------------------------------------------------------------|
| <b>First Annual New Jersey Physicians Conference</b> | May 4-7, 2000   | Atlantic City Convention Center, MSNJ, (609) 896-1766        |
| <b>American Occupational Health Conference</b>       | May 12-19, 2000 | Pennsylvania Convention Center, Philadelphia, (847) 818-1800 |
| <b>AMNJ Annual Awards Dinner</b>                     | May 24, 2000    | Chanticleer, Short Hills, AMNJ, (609) 275-1911               |

**J u n e**

|                                                              |                  |                                                                               |
|--------------------------------------------------------------|------------------|-------------------------------------------------------------------------------|
| <b>17th Symposium for Computer Applications in Radiology</b> | June 3-6, 2000   | Philadelphia Marriott Hotel, (703) 757-0054                                   |
| <b>Meningitis</b>                                            | June 7, 2000     | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>AMA Annual Meeting</b>                                    | June 11-15, 2000 | Chicago Hilton & Towers, (312) 464-5000                                       |
| <b>Rheumatoid Arthritis: A New Look at an Old Disease</b>    | June 14, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Nephrology Society Meeting</b>                            | June 30, 2000    | UMDNJ-Robert Wood Johnson Medical School, New Brunswick, AMNJ, (609) 275-1911 |
| <b>Chronic Pain Management</b>                               | June 21, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |

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# REFLECTIONS

## THE CIDER HOUSE RULES

Leah Z. Ziskin, MD

**T**he historic United States Supreme Court decision on abortion commonly known as *Roe v. Wade* marked its 27th anniversary on January 22. Anyone who had thought this decision would be the final word on the abortion debate was sadly mistaken. Many more decisions followed. Now the US Supreme Court is examining the question of the legality of the "partial birth" procedure, and the NJ Supreme Court is reviewing a state statute mandating that women under the age of 18 notify their parents when they intend to seek an abortion.

Abortion may be the most divisive medical/social issue of the present time. It has divided political parties, voters, religious leaders, hospitals, nurses, physicians, families, and women. It reaches to the core of our personal beliefs. It is an issue where individuals who agree philosophically on many other subjects can find themselves in opposition. It is an issue where statistics and data do not seem to influence or alter positions.

A recently released movie, *The Cider House Rules*, adapted from the novel of the same title by John Irving, gives theatergoers another view of this subject. Irving uses a physician to portray someone who offers every option to "women in trouble." Set in the mid-1940s, the movie portrays a physician who will competently perform an abortion or a delivery or keep unwanted chil-

dren in the orphanage and try to obtain adoptions for them. He teaches his favorite orphan, Homer, obstetric skills, despite Homer's protest that he is not a doctor. Homer leaves the orphanage and faces life situations at least as if not more complicated than those he previously faced.

The "rules" come into play in several ways. There were of course rules at the orphanage. The doctor, nurses, and the orphan knew they were breaking the "rule," or the law of land, when performing abortions. Homer early on voices his distaste for abortions, although he accepts that the doctor performs the procedure only upon request. Later, living and working at an apple orchard, Homer discovers that there are rules posted in the "cider house" where the migrant workers live. The rules, written by the owner of the orchard, are of little relevance to the workers. In a scene in the movie, Homer burns the cider house rules, which causes the viewer to recall when he earlier burned the remains of the products of conception at the orphanage.

Irving, who also wrote the screenplay for the movie, created a powerful portrayal of the multiple facets of this complex human subject. I encourage physicians to read the book and to see the movie. They depict many of the dilemmas faced by women and their partners that cannot be solved, decided, or governed by legislators, judges, or "rules."

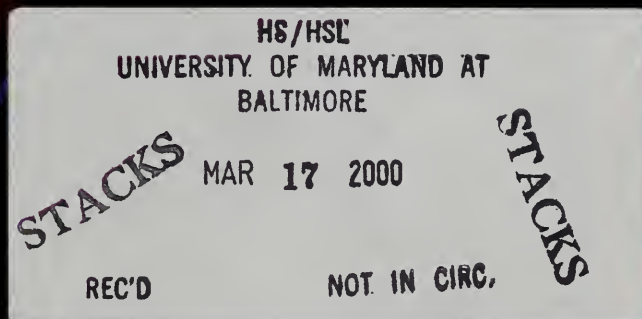


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## Help MSNJ help you with the PIP program

While physicians deplore the new use of protocols in managing the care of auto accident victims under the state personal injury protection (PIP) program, state officials say they're eager to learn about any problems that the protocols cause.

Writing to MSNJ, the Department of Banking & Insurance called on MSNJ members to help "... in monitoring whether reimbursement for medically necessary care of injuries sustained in automobile accidents is being inappropriately or arbitrarily denied by insurers."

A simple one-page complaint form is available for submitting complaints against PIP insurers. Find the form on the recently enhanced MSNJ Web site, [www.msnj.org](http://www.msnj.org), or contact MSNJ staff at telephone extension 245 or 298 or by fax. Members also are asked to inform MSNJ about their complaints, and MSNJ on request will help members prepare complaints.

**New Figures.** New Jersey physicians incur some of the nation's highest professional expenses and may have one of the highest concentrations of solo practitioners. So suggests the latest edition of the AMA's authoritative *Physician Socio-economic Statistics*.

According to the report, self-employed physicians in the Garden State spent an average of \$61,600 in 1997 on such expenses as legal, accounting, and office management services, compared with a national average of \$34,300. While 25.6% of US physicians were solo practitioners in 1998, the prevalence in New Jersey was 35.8%.

In both these categories, New Jersey ranked first among the 10 states for which statistically valid figures were compiled. Still, given the small numbers of respondents, the New Jersey deviations shouldn't be overinterpreted.

We're normal enough, according to the report, in percentage of

practice revenue obtained in 1998 through managed care contracts, per physician. Nationally, 52.4% of revenue came through managed care; in the state, 53.8% did.

US physician income fell 1.2% in 1997 to a median of \$140,000 for primary care physicians and

**S**o long, university-run hospitals? As academic medical centers morph from revenue centers into cost centers, universities are displaying a willingness to abandon their once-prized possessions. A leading case in point, says *Perspectives on the Marketplace*, lies just across the Delaware River at the University of Pennsylvania, whose four-hospital system bled \$198 million last fiscal year.

At Pennsylvania State University (an institution farther to the west that once had pretensions to a major college football team), the Geisinger Health System is being given its freedom from the research-oriented Milton S. Hershey Medical Center. Penn State is lending Hershey \$150 million to get back on its feet and smell the chocolate.

\$195,000 for nonprimary care specialists. The report notes that physicians on average work 40% longer hours than most workers and train for as long as eight years. Average physician income in the mid-Atlantic states was about 3.3% less than income nationwide.



**Reducing Deaths.** While politicians focus on system-related medical errors as a cause of patient deaths, an even greater problem of iatrogenesis is nearly ignored. In a now-famous report, a panel of the prestigious Institute of Medicine estimates 44,000 annual hospital error-related deaths nationwide. But the Centers for Disease Control and Prevention pegs the number of deaths caused by nosocomial (hospital-related) infections at 90,000—twice as high.

Attacking the infection scourge, Northwestern Memorial Hospital in Chicago has constructed a new hospital with all private rooms, a hand-washing sink for health care workers in each room, building-wide air filtering that meets high efficiency particulate air standards, antibacterial fireproofing materials, and a large complement of isolation rooms. The hospital calculates an eightfold benefit for these costly improvements, says the *Healthcare Leadership Review*.

**Senate Hopeful Declaims.** Jon S. Corzine, considered by some the leading candidate for the Democratic nomination to succeed retiring US Senator Frank R. Lautenberg, described an all-too-frequent scenario in a key health policy speech.

"A few doctors manage to make the system work," related Mr. Corzine, "by having armies of assistants sending out bills and forms and seeing many more patients in a day than they would choose. Caregiving cannot be reduced to mere commerce. Volume discounts," he added, "belong in supermarket aisles, not the halls of medicine."

The would-be senator declared support for universal insurance for children, mandatory coverage offerings by large employers, subsidies for other workers and families, mandatory family planning benefits, a patient bill of rights, and compulsory reporting of medical errors.

**Corporate Medicine.** Economist James C. Robinson of the University of California-Berkeley School of Public Health has authored a new view of medical practice. In *The Corporate Practice of Medicine: Competition and Innovation in Health Care*, Dr. Robinson suggests that the melding of physicians into large groups and systems is a desirable response to positive, radical, and dominant forces of competition.

Decrying the traditionally over-regulated health care system and

the tendency to consider health care different from other sectors of the economy, Robinson nonetheless emphasizes the importance of physicians as "the central figure in health care." Physicians, he says, control 80% of the trillion-dollar industry.

The health economist stresses the emergence of independent practice associations (IPAs), which may succeed in preserving physician dominance if physicians develop loyalty to them. IPAs will succeed, he intimates, if physicians agree to accept IPA controls that boost patient satisfaction, efficiency, and cooperation.

A strict adherence to patient choice of providers and services, notes Robinson, is incompatible with efficiency. So, the challenge is to strike a balance between corporate control, which could overwhelm people and homogenize care, and individual physician control, which could generate inefficiencies and resist quality improvement. "Everything should be made as simple as possible, but not simpler," declared Albert Einstein, the New Jersey resident in his mature years whom *Time* magazine recently dubbed the "Person of the Century."

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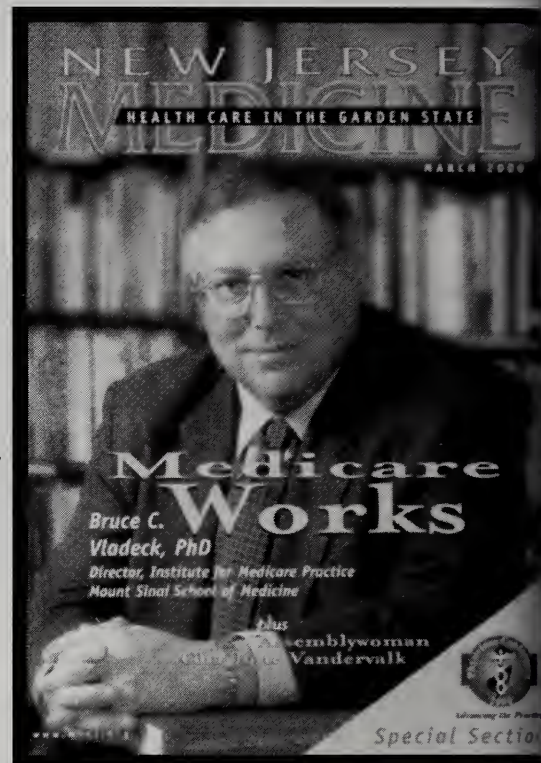
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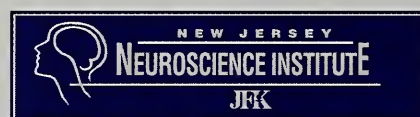
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## MEDICARE, DR. VLADECK, AND THE FUTURE

The Medicare program may be the single most powerful force in determining the course of health care in the United States. It spends more than \$200 billion a year and represents about 10% of the federal budget. Medicare insures those who are the most intensive users of health care services and is the largest single source of health care financing in this country. It tends to lead change in other areas of health care. It sets a standard for reimbursement of medical services. It has a far-reaching and extensive impact on medical care in this country, from the health of our population to the economics of health care, from quality measures to social and societal change.

Bruce C. Vladeck, PhD, a former assistant commissioner of health in New Jersey, was the administrator of the Health Care Financing Administration (HCFA), which directs Medicare and Medicaid, from 1993 to 1997. In his position with HCFA, Dr. Vladeck had an enormous impact on the agency, on Medicare, and on health policy in this country.

In this issue, *New Jersey Medicine* is pleased and honored to publish Dr. Vladeck's analysis of the critical program that he directed. His expertise is beyond question, and we believe that a wide audience, beyond the readership of this journal, will be interested in his insights and thoughts about the subject.

*New Jersey Medicine* also interviewed Dr. Vladeck. We questioned him about the Medicare program as well as long-term care, fraud and abuse, and other issues.

He is modest about his own achievements but is proud of the accomplishments of HCFA. He is particularly pleased with the change in the culture of HCFA, for recognizing that its primary constituency is the beneficiaries rather than congressional leaders.

In his current position as director of the Institute for Medicare Practice at the Mount Sinai School of Medicine in New York, Dr. Vladeck will, we believe, continue to play an important role in the formulation of America's health policy. He cares deeply about the quality of care and about the mechanism of the delivery of care. His goal at the institute is a melding of clinical experience with policy expertise in practical planning and in policy development.

Dr. Vladeck is a graduate of Harvard University and received his PhD from the University of Michigan. He believes he inherited his work ethic from his parents (both lawyers) and that his children also seem to have inherited it. (His mother, he notes, has a busy practice in employment law and still works six days a week.)

In an article published in *JAMA* in July 1995, Dr. Vladeck stated that "...HCFA cannot lose sight of its mission to administer Medicare in a responsible, cost-effective way and to think strategically about how Medicare can serve the beneficiaries of the future." That was good advice to the agency then, under other circumstances and while he remained at its head, and remains important today.

**Leah Z. Ziskin, MD, and Paul J. Hirsch, MD**



## NATIONAL PUBLIC HEALTH WEEK

Many of us can recite the outstanding accomplishments of public health in the past that have significantly lowered morbidity and mortality:

- Ensuring a safe potable water supply and sanitary sewage disposal.
- Ensuring a safe food supply, including the pasteurization of milk.
- Immunizing children and adults.
- Identifying and controlling infectious disease epidemics.

But what is the value of public health today? What are the issues that need to be addressed? Can the traditional public health approach make a difference?

Today, public health is facing some of its greatest challenges ever. Our population is aging and the types of health care needed require reshaping. Adolescents struggle with teen pregnancy, sexually transmitted diseases, and violence. The abuse of tobacco, alcohol, and other drugs underlie the leading causes of death and lead to the early disruption of lives. Violence and terrorism are increasing fear and anxiety among all age groups as well as causing death and inflicting physical harm. Occupational and environmental disease and injury are demanding attention. The HIV/AIDS epidemic is not over, and there is a need to be vigilant in detecting the emergence and reemergence of infectious diseases.

Poverty, race, and ethnicity have profound influences on health status. Physicians and hospitals have felt the effects of the major changes in the health care delivery system with the penetration of managed care. The practice of public health has not been spared. The large number of uninsured has affected both the utilization of public health services and the practice of medicine. Clinicians and facilities lose when there is no third-party payor. Public health loses when an individual is denied access to care or delays seeking care because of being uninsured or unable to pay. Further, public health officials are voicing increasing concern over insufficient resources to support the very core of public health programs.

Public health professionals approach problems with a variety of tools and play a variety of roles. First and foremost, public health agencies collect vital information about the population and use their repository of vital statistics and disease reports to quantify and define health problems. Through the surveillance of records, mortality and morbidity are tracked, trends documented, and epidemics identified. These are the disciplines of epidemiology and biostatistics. These records are shared among researchers, clinicians, and the public. In this role, health departments are serving as public relations agencies, deciphering the information they collect and making it understandable to others.

Health departments also make judgments about the information's significance and propose solutions or ways to improve, control, or eliminate difficulties, acting as a program developer or an evaluator.

When the solution to a problem requires standard setting, quality assurance guarantees, inspection and licensure or accreditation, a health department finds itself in the role of regulator.

Some are questioning whether these traditional approaches to public health issues are still valid. Until we formulate and test newer ones, we should continue using methods that have led to past achievements.

The public health challenges of today are very important to society and medicine. A health department fulfilling its responsibilities to the public is a strong partner to medicine and furnishes the community with services not usually provided in the practice setting.

Five years ago the idea of a week to reflect on what public health means and to honor those who work in public health took shape. Across the nation, state health departments and public health associations are now preparing for National Public Health Week, to be held April 3-9, 2000. Let this week be a time for New Jersey to celebrate its accomplishments and decide its priorities for the future.

Leah Z. Ziskin, MD  
Cherry Hill

## COVERAGE WE CAN COUNT ON

The final installment of HIP's payout on January 4 should have signified the culmination of New Jersey's health insurance miseries. It didn't. The problems associated with bankrupt insurance companies will exist, and there's nothing in place that will prevent the HIP debacle from recurring. The state must do something immediately to prevent an HIP sequel.

New Jersey patients invest their money in managed care programs with the understanding that medical coverage will be available in the time of a crisis. After all, New Jersey automobile, homeowner, and all other types of insurers are required to pay into a "guaranty fund," which ensures customers will receive the insurance benefits they paid for, even if their insurer goes bankrupt. But as HIP

patients discovered last year, such coverage is not a certainty in New Jersey when it comes to one's health care.

As a physician, I find it appalling that New Jersey places all other insurance in higher regard than one's health care. Creating a guaranty fund for managed care organizations is the only solution to this problem. This low-cost proposition will provide a safety net for patients and guarantee that the medical coverage they already paid for is protected—even if a managed care organization goes belly-up.

New Jersey must require guaranty funds for health care providers to ensure that the most important coverage—one's health care—is always protected. Anything less is an injustice to patients.

**Irving Ratner, MD**

**President, Medical Society of New Jersey**



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## UPDATE ON THE NATIONAL GUIDELINE CLEARINGHOUSE (NGC)

The National Guideline Clearinghouse (NGC) is a comprehensive database of evidence-based clinical practice guidelines and related documents produced by the Agency for Healthcare Research and Quality (AHRQ) (formerly the Agency for Health Care Policy and Research [AHCPR]), in partnership with the American Medical Association (AMA) and the American Association of Health Plans (AAHP). The NGC continues to become a deeper repository of information to assist with clinical decision-making and patient counseling. It now offers access to more than 600 evidence-based clinical practice guidelines, related summaries, and other material.

The NGC mission is to provide physicians, nurses, and other health professionals, health care providers, health plans, integrated delivery systems, purchasers, and others an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation, and use. It contains guidelines submitted by more than 125 health care organizations, associations, and medical societies.

The NGC database offers both simple and detailed search options along with the ability to browse by disease/condition, treatment/intervention, or the name of the guideline developer. Users can find out what has been recently added by clicking on the "What's New" button.

Key components of NGC include:

- Structured abstracts (summaries) about the guideline and its development.
- A utility for comparing attributes of two or more guidelines side-by-side.
- Syntheses of guidelines covering similar topics, highlighting areas of similarity and difference.
- Links to full-text guidelines, where available, and/or ordering information for print copies.
- An electronic forum, NGC-L, for exchanging information on clinical practice guidelines, their development, implementation and use.
- Annotated bibliographies on guideline development methodology, implementation, and use.

For more information, call (301) 594-4042 or e-mail [info@ahrq.gov](mailto:info@ahrq.gov).

## INTERNET EFFECTIVE IN IMPROVING PATIENTS' COMPLIANCE TO DRUG TREATMENT SCHEDULES

The Internet provides powerful tools to help increase treatment compliance among people with chronic conditions, according to findings by Cyber Dialogue. Data from Cyber Dialogue's Cybercitizen Health survey of American adults found that one-third of chronic disease sufferers who seek disease information online report taking their medications more regularly following a visit to a disease-specific Web site.

Poor compliance to prescribed medications has been a major problem in health care for decades, particularly among patients with chronic conditions such as heart

## BOOKMARKS

<http://www.ama-assn.org/members/cits>

A Web site to help AMA members better comply with laws, regulations, and policy shifts that govern fraud-and-abuse-enforcement activities. It also provides links to other online resources, such as fraud alerts from the Department of Health and Human Services' Office of Inspector General, Health Care Financing Administration advisories, and government regulations.

<http://www.sharenj.org>

The Web site for the Sharing Network, New Jersey's source for organ donation and transplantation information, contains information on how to become an organ donor and related information.

<http://www.cponline.gsm.com>

An online drug information service that uses information from *Clinical Pharmacology CD-ROM*, published by Gold Standard Multimedia, Inc., Tampa FL. The public portion of the database provides excerpts from full monographs on the most common and classic medications in clinical practice. Complete monographs for these drugs, including dosage, contraindications, interactions, adverse reactions, costs, product ID, and classifications, are available in the subscriber area; access to the subscriber area is \$345/year.



disease, HIV infection, depression, and hypertension. Industry-standard studies have confirmed that 30% to 70% of prescription medications are not properly administered, leaving thousands of patients undertreated and adversely affecting insurance costs.

"The Internet has the power to change the concept of 'take as directed' by improving patients' understanding of the importance of compliance," said Thaddeus Grimes-Gruczka, vice president of Cyber Dialogue's Health Group.

"Previous efforts to improve compliance had limited success, but new options such as e-mail reminders and online health management programs can provide the support and privacy patients demand."

Cybercitizen Health's study also revealed that 54% of chronic disease sufferers who seek disease information online reported asking their doctor about a particular treatment after learning about it online. This suggests that the Internet may be a more powerful method of motivating patients than traditional media.

Other Cybercitizen Health findings include:

- 12.3 million online health information users currently take prescription drugs.
- 10 million US adults seek pharmaceutical content online.
- 62% of online health information users trust online health information when the "site isn't trying to sell anything."

For more information, contact Joe Farris at (212) 651-7043 or [jfarris@cyberdialogue.com](mailto:jfarris@cyberdialogue.com).

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# MEDICARE WORKS

*Bruce C. Vladeck, PhD*

For those of us engaged in the delivery of health care outside the Washington beltway, there is a certain air of unreality to Washington discussions of Medicare. We certainly have plenty of quarrels with how much Medicare pays for certain services, what it does and doesn't pay for, and how it operates; but to listen to the Washington debate one would think Medicare was some sort of anachronistic relic inferior in every way to the modern and creative private insurance industry. Calls for "reform" of Medicare by many in Congress amount to efforts, implicit or overt, to further privatize it by handing it over to the insurance industry. Compared with how the private sector actually appears to be working these days, however, that would leave many beneficiaries and most service providers substantially worse off. The fact is that in many basic but very important ways, Medicare works, reasonably to extremely well. And it works a lot better in those particular ways than anything else in the current US health system.

In the real world, Medicare appears to work fairly well with regards to the following:

- For people over 65, it provides universal coverage.
- Once people enroll in Medicare, they stay in Medicare, without being bounced in and out of insurance status or from plan to plan.
- Medicare beneficiaries are about the only Americans who really have a choice about where to get their care, whether or not to enroll in a managed care plan, and which plan to enroll in.
- Medicare is entirely portable within the United States; beneficiaries can get care and providers can get paid no matter where they are when illness or injury strikes.
- Medicare pays its bills.
- Medicare provides the financial backbone for teaching hospitals, rural hospitals and clinics, and much of the rest of the essential infrastructure of the health system.
- While there are lots of specific technical and philosophical problems, Medicare's pricing systems for hospitals, physicians,

and many other services provide the publicly available and accepted template for price negotiations or fee-setting for most other payors.

- For those engaged in research about health services or health policy, Medicare data, for all its limitations, is the most complete, accurate, and accessible data available in this country.
- Medicare has made possible the development and provision of an extraordinary range of services to older Americans—and the outcomes, in improved health and increased disability, are demonstrable.
- Medicare beneficiaries, unlike a growing proportion of other Americans, are highly satisfied with their health insurance.

## Medicare as Insurer

Within recent memory, the fact that Medicare provides health insurance to essentially every American over the age of 65 (as well as everyone with end-stage renal disease and a large fraction of the permanently disabled) merely meant that the elderly differed from the rest of the

This article was supported by The Commonwealth Fund, a New York City-based private independent foundation. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff.



population in the source of insurance. Now, having health insurance at all is a more notable characteristic. In the ninth year of the longest sustained economic boom in US history, almost one in five Americans under the age of 65 has no health insurance whatsoever. That proportion has grown steadily over the past decade. One can only imagine how rapidly it will grow when the economy finally weakens.

While shifts in the political climate and a growing sense of nihilism about the possibility of broad social reform may have dampened efforts to achieve universal health insurance in the United States, no one argues that this isn't still a desirable goal. With the recent political changes in South Africa, the US is now the *only* industrialized nation in which a large proportion of the working-age population is uninsured. In that regard, Medicare is now one of our last links to the rest of the civilized world.

From the point of view of health care providers, services to the uninsured represent a growing and potentially unsustainable financial burden—even though, controlling for differences in health status, the uninsured are far less likely to seek and receive health care when they need it. And even when a subsidy is available to providers to defray some fraction of the costs of caring for the uninsured (in many parts of the country, the most generous such subsidies are those provided by Medicare), obtaining payment requires considerable administrative

hassle for both patients and providers.

Reliance on employment-related fringe benefits as the principal vehicle for providing health insurance to the nonelderly also means that—in a world of relatively frequent employment changes, heightened efforts by employers and insurers to coordinate benefits among family members, and changing patterns of family relations—even people who never go without health insurance are likely to encounter changes in health insurers, with concomitant changes in how they obtain their health care. These effects of ordinary labor-market and family pressures are exacerbated by the growing willingness of employers to switch health care coverage—or induce switches in health care coverage—for their employees from one limited-panel plan to another. No one has done a full accounting of the economic, psychic, and health care costs imposed on individuals and health care providers by this kind of churning

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in health insurance, but most of us non-Medicare beneficiaries have become accustomed to periodic disruptions in coverage. At a minimum, such disruptions cause considerable annoyance to those who actually read their plan information. At a maximum, a disruption can severely interfere with patterns of care for people with significant chronic conditions who have become highly dependent on relationships with particular physicians or hospitals. Most Medicare beneficiaries don't have these problems. And Medicare doesn't impose these hidden costs on service providers.

With some limited exceptions (discussed below), the only Medicare beneficiaries required to change their health care arrangements because of changes in their health insurance are those who choose to do so, by voluntarily electing to enroll in managed care plans, changing plans, or returning from managed care to fee for service. The rhetoric of "consumer choice" or "patient choice" dominates much of the contemporary health policy debate, but most Americans who receive their health insurance through employment have very little choice about their health care plans. In 1997, 57% of privately insured individuals had no choice of plans.<sup>1</sup> When the dominant model of health insurance was a pure indemnity system, the lack of choice made little difference to most consumers, who could receive their medical care from any physician or hospital willing to see them; now, however, almost all private insurance is "managed" at least to the extent of limit-

ing the number of providers for whom insurance payment is available. Medicare beneficiaries dominate the shrinking minority of Americans who really do have a choice in their health insurance arrangements.

In the fall of 1998, when a number of HMOs announced that they were withdrawing from Medicare participation as a result of changes in payment and regulations created by the Balanced Budget Act of 1997, more than 400,000 Medicare beneficiaries were involuntarily terminated from their plans and had to make other arrangements, although almost all of them had the option of enrolling in another Medicare HMO in addition to returning to fee-for-service Medicare. An enormous hullabaloo erupted, complete with congressional hearings and reams of newspaper stories. Yet this experience affected fewer than 2% of Medicare beneficiaries. It got so much attention precisely because it was so unusual in Medicare; it is so common in private insurance that it hardly ever receives any public attention at all.

The gradual disappearance of indemnity-style insurance in the private sector has posed an additional problem for many American families. In this most geographically mobile of societies, indemnity insurance plans were largely indifferent to the site at which service was rendered; medical care away from home, at least in the United States, was generally covered to precisely the same extent as medical care in one's hometown. The same generally does not apply to limited or closed-

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network plans. Every family with a child away at college has had at least one experience with this issue, as have many people who must travel extensively for business. From the provider's perspective, "foreign" insurers are always a headache and frequently a source of nonpayment.

Fee-for-service Medicare, of course, is completely portable within the United States. Indeed, one of the reasons for the relatively smaller percentage of Medicare beneficiaries enrolled in managed care, compared with the privately insured, is precisely the issue of out-of-area coverage: as more and more retirees spend parts of the year away from their primary residences, the inability of the managed care industry to develop effective reciprocity or out-of-area coverage arrangements for a

population always vulnerable to needing services is a major deterrent to managed care enrollment.

### Medicare as Payor

Even though they're the ones responsible for printing it, the government of the United States and the people who make policy for it have almost no concept of cash. The budgeting process for the US government systematically ignores the time value of money, and the expenditure control mechanisms in the executive branch concentrate on funds that are "obligated" rather than those that are actually expended.

In general, there is a lot to be said for the virtues of accrual accounting, but health care remains largely a cash business, for the simple reason that most of the costs incurred by providers of health care, from the largest hospitals to the smallest physician offices, are for compensation to individuals who expect to be paid in cash or its paper or electronic equivalents every week or two. Because of insurance, health care providers are rarely paid in full at the time they deliver a service (and incur the associated personnel and other costs); generally, the provision of service creates only the opportunity for the provider to generate a bill. Cash flow is thus a constant preoccupation of all but the most affluent or incompetent health care providers.

Although it receives almost no attention within the Washington policy community, the fact that Medicare pays most of its bills quickly and completely is indispensably important to most hospitals and



home health agencies (although recent changes in the administration of the Medicare home care benefit have caused traumatic cash flow problems for many home care agencies) as well as many larger physician practices, equipment suppliers, and others. By law, Medicare is required to pay "clean" claims within 27 days when they are submitted on paper and within 14 days when they are submitted electronically, as the overwhelming proportion of Medicare claims now are. "Clean" claims are those that are technically accurate and that are not pulled out of the process for manual medical or program integrity review. It is incontrovertible that until recently Medicare was paying too high a proportion of claims quickly and automatically, at least from the viewpoint of optimal program administration and prevention and detection of fraud or abusive practices. As in home health, recent efforts to tighten up on the Medicare payment process have reduced the rapidity of Medicare cash flow for many providers. But even slowed down as much as it has, Medicare still pays faster and more completely than most private insurers. Not unrelatedly, it also pioneered in the implementation of electronic billing and remittance systems, thus not only facilitating cash flow but also reducing paperwork and administrative expenses.

On the other hand, private insurers, including private managed care firms, do understand the time value of money; indeed, that is how they make their living. In the not-so-distant past, insurers could be rea-

sonably confident that they would make money if their total claims experience was no greater than their total premium revenue, so long as premiums were paid sufficiently far in advance so they could optimize the float. As the major customers of private insurers—the larger employers—caught on, they discovered the virtues of self-insurance, which allowed them to keep the float for themselves. By the late 1970s, when inflation and interest rates were high, they began more systematic efforts to hold onto their cash. When combined with the advantages of operating plans under federal ERISA law rather than state insurance regulation—advantages that have existed since ERISA was enacted in 1972 but were not fully rat-

ified by the courts or fully recognized by employers until much more recently—the power of cash flow has led almost every employer of more than a few hundred people in the United States to self-insure for those health benefits not delivered by capitated plans, employing insurance firms only as third-party administrators to manage provider networks and process claims. In turn, one of the reasons so many traditional health insurers have sought to move out of the indemnity business into managed care—or move out of health care altogether—is that, in a world in which the employers hold on to their cash, the profitability for insurers has dried up.

But if the increasing sophistication of large purchasers and third-party administrators about cash flow has had an adverse effect on the providers of service, the impact pales in comparison with the payment practices of many HMOs. For a variety of reasons, HMOs in many markets are simply not paying their bills from providers on a timely basis, or at all.

The essence of HMO administration, in its most common contemporary form, is the interposition of a review process between the submission of a provider claim and its payment. In theory, and sometimes in practice, this review provides the HMO an opportunity to discourage unnecessary or marginally necessary services, alter the practice styles of wasteful or inefficient physicians, and even improve the quality of care. In practice, this delay often permits HMOs that are not terribly well-managed—or that are trying to

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inflate quarterly financial results, or that are simply short on cash—to defer payments of valid claims for many months while they are bounced back and forth through a series of real or fictitious internal processes.

More basically, HMOs are put “at risk” by contracting to provide medical services to an enrolled population in exchange for a fixed monthly premium, a risk that is often exacerbated by competitive pressures in the HMO market to keep premiums low. HMOs, however, have managed to transfer a sizable proportion of that risk to the health care providers, through such formal mechanisms as partial payment withholds or “shared risk” pools or, not infrequently, by simply defaulting on their payment obligations altogether. In New Jersey alone—not a state characterized by an especially high penetration of managed care plans—in just the past 18 months providers have had to deal with the administrative burdens and interruption of their income streams that resulted when two HMOs became insolvent, went into bankruptcy, or otherwise walked away from their payment obligations. In a competitive private insurance market, some competitors are bound to fail, and without significantly stronger protections than now exist, those failures will continue to have an adverse emotional and often practical effect on their enrollees and a calamitous financial effect on the providers of service with whom the HMO did business.

Not only does Medicare pay more quickly than just about any other

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third party, but to certain classes of providers it pays more generously as well. As the largest single health insurance program in the US and the most important governmental health care program, Medicare simply cannot get away with the cheapest possible price. It also has an obligation to contribute to the infrastructure of the health care system itself. Thus, Medicare pays more than it otherwise might to teaching hospitals, which helps subsidize the educational, scientific, and intellectual infrastructure that supports the entire health care system for all Americans. In proportional terms, its subsidies to small rural hospitals are even greater. Without those subsidies, many such facilities could not survive and would leave their communities—including not only the Medicare beneficiaries who

reside in them but all the residents—without nearby hospital services. Similar, if less generous, subsidies are also provided to hospitals, both urban and rural, that treat relatively large numbers of low-income people; primary care outpatient clinics in rural areas; and even independent health practitioners in rural communities.

However solid the public policy rationale may be, there is no question that certain political forces have contributed to the development and maintenance of some of these subsidies in the Medicare system. But that is just to say that, as a public program, Medicare does not, and probably should not, behave like a classic economic organization. Consider the alternative: a growing body of evidence indicates that, as the private health insurance market has become more competitive in the past decade or so, the supply of such public goods as charity care for the poor or clinical research in academic medical centers has been reduced. In general, several studies have shown that the higher the penetration of private managed care plans in a given market, the lower the amount of research and charity.

However much Medicare actually pays to providers, the formulas it employs to determine how much it will actually pay for particular services are detailed, complex, and arcane. They are understood in full by only a small number of cognoscenti within the Health Care Financing Administration and the provider and consulting community and widely derided for their length, mathematical complexity, and ob-



curity. Yet they are literally indispensable. In this kind of society, a public program engaged in the expenditure of billions of taxpayers' dollars must shape its spending decisions to reflect a myriad of interests and concerns and must do so in a way that is intellectually defensible, publicly accessible, and reproducible. More relevant, for the purposes at hand, Medicare's payment formulas literally are the state of the art, not only in terms of their sophistication, but because most other payors rely heavily on them.

In most of the United States, for example, the much-maligned resource-based relative value scale on which Medicare sets its physician fee schedule is employed, in some variation or another, by most private insurers to set or evaluate their physician payments. In the New York market, along with many others, HMOs negotiating with physicians or their representatives set their fees as a percentage of the Medicare fee schedule. Advocates for replacing the current Medicare program with one that would resemble the Federal Employees Health Benefits Program (FEHBP) frequently advance their arguments by pointing out how much smaller the FEHBP administrative structure is than Medicare, thereby ignoring, among many other things, the fact that most of the private insurance plans participating in FEHBP use Medicare payment methodologies for some if not all of their provider payments, and even those that don't use Medicare rates are legally permitted to impose them if they are unable to reach alternative contrac-

**CASH FLOW IS  
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PREOCCUPATION OF ALL  
BUT THE MOST AFFLUENT  
OR INCOMPETENT HEALTH  
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tual agreements with providers (an authority eagerly sought by FEHBP itself).

**Medicare and the Public Good**

As a public program, Medicare makes available to essentially anyone a wealth of data about the health care system and how it is used by its beneficiaries. At the same time, it maintains an unsurpassed record of protecting the confidentiality of individual beneficiaries (an accomplishment made easier by the nature of the criminal penalties in the federal Privacy Act for unauthorized dissemination of beneficiary-specific data). Again, this was not such a big deal a decade or so ago, when the Health Care Financing Administration made little effort to make its data publicly accessible and when there were plenty of alternative sources. But changes in the private health care system, especially in combination with continued stringency in government budgets, have led to the drying up of many other data sources. Public data repositories in communities throughout the country have gone out of business as health insurers and providers increasingly treat information about

enrollees, utilization, payment, and revenues as proprietary competitive information. But any individual anywhere in the world who wants some basic information about providers of health services, expenditures (by all payors), or patterns of use by Medicare beneficiaries need only to go to the HCFA Web site.<sup>2</sup> Researchers or others who want more detailed data on facility costs and revenues, health care utilization, or the relationship between beneficiary characteristics, utilization, costs, and outcomes must go through a slightly longer, more complex, and more expensive process to obtain the data from HCFA, called a data use agreement.

Information is also, in many ways, a public good, one that becomes particularly important in an information society in the information age. And while many apologists for private insurers and health plans claim to support the requirements that they make much more information about health care and the health system available to the public, the fact is that those insurers and plans aren't doing so, even when required by law.

Data derived from the Medicare program itself is only one of the sources from which it has become increasingly clear over the past several years that Medicare works, perhaps surprisingly well, on the most basic and important dimension of its performance as well. Medicare beneficiaries are substantially healthier than they used to be, and they are getting healthier all the time. Their life expectancy has increased and will continue to; rates

of disability have fallen dramatically; diseases that used to literally or figuratively destroy the lives of older people can now often be successfully treated, even cured.

Of course, not all of the improvements in the health of older Americans can be fairly attributed to Medicare. Improvements in medical practice, socioeconomic and behavioral changes, and perhaps most important, scientific progress undoubtedly deserve the lion's share of the credit. But the portion of that improvement that can be accurately credited to Medicare is surprisingly high. For example, Manton et al. found that while life expectancy for most Americans still trails that of their counterparts in other Western nations, for people over the age of 65 the United States does pretty well.<sup>3</sup> And it does even better for people over 80. And much of that difference, Manton argues, is due to the availability of Medicare and the continued willingness of Medicare to pay for technologically intensive services (such as joint replacements or cardiac surgery) for people in their late 70s and 80s.

It's perhaps no wonder, then, that the overwhelming proportion of Medicare beneficiaries report themselves moderately to highly satisfied with their health insurance. For the purposes at hand, it is especially worthwhile to note that Medicare beneficiaries are about 50% more likely to report themselves satisfied with their health insurance arrangements than people with private coverage—even though the insurance benefits in most private plans are now substantially more

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generous than Medicare's. In other words, Medicare works reasonably well in the opinion of the most important judges—its beneficiaries.

In their positive feelings toward Medicare, beneficiaries are not, in fact, very different from younger Americans, who continue to overwhelmingly support the program and rank it among the most important things that government does in this country. In a democratic society, that is not an unimportant consideration.

There are many things wrong with Medicare as it is currently configured and operated. Most basically, it covers a diminishing proportion of the health care costs of its beneficiaries, as a result of an outdated structure of copayments and deductibles, the absence of any ceiling on individuals' out-of-pocket liabilities,

and most especially, under current circumstances, the absence of any coverage for outpatient prescription drugs. The reliance on payroll taxes to support a large share of Medicare's expenditures clouds its financial future in a world in which nonwage income and health care costs generally grow faster than wages. And the political intensity with which Congress and the White House seek to micromanage Medicare operations makes it difficult for program managers to effectively deploy modern data processing, purchasing, or medical monitoring techniques. But in the debate about Medicare's future, it's important to be reminded of what works and what's worth saving as well as what's wrong. On a number of important dimensions, it's certainly far from clear that any of the real-world alternatives could do any better. And in the general context of contemporary American health policy, applying major changes to one of the few things that is working seems a rather backward way to proceed. ■

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**- Gus Mongiello, Vice President and Chief Financial Officer, Hackensack University Medical Center**

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# Bruce C. Vladeck, PhD

*Director, Institute for Medicare Practice  
Professor, Health Policy and Geriatrics  
Mount Sinai School of Medicine*



Bruce C. Vladeck, PhD, is a former assistant commissioner of health in New Jersey (1979 through 1981) who has gone on to great national prominence in the field of health policy. Perhaps his most notable position was as administrator of the Health Care Financing Administration (HCFA) of the US Department of Health and Human Services from 1993 through 1997. Before that, he was president of the United Hospital Fund of New York for 10 years and also served as an assistant vice president at the Robert Wood Johnson Foundation in New Jersey.

At HCFA, Dr. Vladeck was responsible for administering and overseeing the Medicare and Medicaid programs, covering more than 65 million people, with combined annual expenditures of more than \$300 billion in 1997.

He currently is director of the Institute for Medicare Practice and professor of health policy and geriatrics at Mount Sinai School of Medicine in New York. He is also senior vice president for policy at Mount Sinai NYU Health. The Institute for Medicare Practice was formed in 1999 as the health policy center of Mount Sinai School of Medicine and Mount Sinai NYU Health; it is the only applied Medicare policy center in the country addressing Medicare issues from the base of a major clinical enterprise. The institute's mission includes



integrating health policy and practice—bridging the two cultures of practitioner and policymaker—by bringing together and working collaboratively with researchers, practitioners, educators, and consumers to improve Medicare and the services provided to Medicare beneficiaries.

Dr. Vladeck and his colleagues at the institute will give particular emphasis to overcoming disparities among Medicare beneficiaries based on barriers due to race, ethnicity, and socioeconomic factors. Other current areas of focus include prescription drug coverage for Medicare beneficiaries in New York; long-term care; the policy, practice, and ethics of family caregiving; and improving care of the frail elderly as they move among health care institutions (e.g., nursing homes, inpatient hospitals, emergency rooms, home and ambulatory care services and facilities). They are also examining whether measurement of the functional status of hip-fracture patients four to six months post-surgery can serve as a reliable outcome measure. The institute is also working collaboratively with the East Harlem Diabetes Center of Excellence and with local clinicians and community organizations to improve the health of people with diabetes.

We were pleased to learn that Dr. Vladeck has returned to this region from Washington DC. *New Jersey Medicine* (represented by associate editor Leah Z. Ziskin, MD, and editor-in-chief Paul J. Hirsch, MD) interviewed him in his offices at Mount Sinai School of Medicine in New York City. Also present during

our conversation was Ann D. Gross, director of communications for the institute.

(An editorial related to this interview appears in this issue.)

**New Jersey Medicine:** What were your most important accomplishments at HCFA?

**Dr. Vladeck:** There were three things that I would emphasize.

First, we made it an explicit policy and organizational imperative that our primary customer was the Medicare beneficiary and our primary purpose was to serve beneficiaries. We improved our communication through mailings and our Web site. HCFA is an organization that thinks about beneficiaries and communicates with them. That is what I am proudest of.

Second, we saved the Medicaid program. As part of the "Contract with America" budget in 1995, there was an intent to convert Medicaid to a block grant. Even after President Clinton vetoed it, there was a concerted effort on the part of Republican governors and many congressional leaders to radically transform the program into a disguised block grant program. A lot of

people worked extremely hard to make the case for preserving the entitlement status. It was not until the spring of 1996 that we knew how the president would act. Eventually, the president made the right decision and maintained the program's status. Had we failed, I think the effects on access to health care for low-income Americans in many parts of this country would have been calamitous.

(The hardest thing about being HCFA administrator in the Clinton administration was that the president was a former governor who liked governors, at a time when governors were trying to reduce the involvement of the federal government but take all its money.)

Third, we began to make real progress toward improvement of the postacute care side of the more medically intensive aspects of long-term care. There were important developments in quality-improvement measures and quality assurance across the spectrum, from home care to rehabilitation facilities to nursing homes.

On a purely organizational basis, we mainstreamed the regional office leadership of HCFA into the policy-making process. Almost 40% of HCFA's staff are in the regional offices. Over time, in a country as big and as complicated as ours, with a health care system as heterogeneous as this one, even a national benefits program like Medicare needs to be administered in a way that is responsive to the idiosyncrasies and characteristics of local communities.

**NJM:** How concerned are you about fraud and abuse in Medicare?

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**Dr. Vladeck:** The first thing I would say is that, in recent years, physicians have been disproportionately frightened by these issues. In reality, very few practitioners have run afoul of the legal system.

When I got to Washington in 1993, essentially all of the mechanisms within the Medicare program to prevent, detect, and deter fraud and abuse against the program had been dismantled in the previous decade. There was no high-level person at HCFA who had a full-time responsibility for program-integrity issues. The "cops" had all been laid off.

There was a very severe problem with fraud and abuse, but it was not universal. It was highly concentrated in certain parts of the country and in certain parts of the industry. More of HCFA's resources, as well as those of the inspector general and the Department of Justice, were channeled into these activities.

We now may have more resources being devoted to health care fraud and abuse than we have health care fraud and abuse. In another few years, however, these resources are likely to be dismantled, as was done in the 1980s, rather than reduced in a rational manner.

**NJM:** How can we improve our approach to long-term care?

**Dr. Vladeck:** I have a long-held belief, buttressed by evidence we saw at HCFA, about the lack of disparity between patients going to nursing homes and those going to home care and rehabilitation facilities. One of the proudest accomplishments of the earlier part of my career was that I basically abolished the distinction between skilled nursing facilities and

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intermediate care facilities, which serves no purpose other than to permit states to countenance some inadequate facilities in a number of places.

The question is: "Can the system be focused on the actual clinical needs of the patient, rather than on a set of bureaucratic categories?" By "clinical needs" I mean medical, social, and functional needs. HCFA has been experimenting for a long time with case mix-based payment for nursing-home patients. They are now developing case-mix systems for home care rehabilitation and other aspects of chronic care. They have begun to develop quality measures based on standardized assessment, from which treatment goals can be developed and the extent to which goals have been met can be measured.

The key is to unify the assessment instruments, and to begin to talk about moving toward unifying the related processes of care planning, goal setting, and pricing. And that is happening, although not as quickly as I would like.

**NJM:** Why have areas such as home care been so difficult to regulate?

**Dr. Vladeck:** Although it may be only in the past 30 years that we have begun to systematically document health care delivery, people have

been practicing medicine in a pretty formal way for thousands of years and in a scientific way at least since Flexner. It has taken time to establish clinical practice guidelines for home care, because they did not exist to the same extent that they did for general medicine.

The population that needed these services in the past was smaller. And the services became common only when the financing mechanisms for them became available. For a long time we in HCFA pretended that there was a clinical base in home care and nursing home care analogous to what there was for general hospitals and physicians, but it just did not exist.

**NJM:** Are you willing to get into the realm of reimbursing the family for giving care?

**Dr. Vladeck:** That is a real issue and one to which we are giving a great deal of thought.

I think that from an intellectual point of view, the notion of providing economic compensation, whether cash or tax credits, to family caregivers is conceptually indefensible. It represents a total triumph of a radical individualism at the expense of any notion of family structure or family obligation.

Although I think paying the family caregiver is the wrong solution, there are several real problems here. The first is the continued economic disadvantage experienced by middle-aged women in the labor market and in the economy. Unpaid caregiving is just one of many economic burdens often assumed by this group. The second part of this is the extent to which our paid caregivers are not trained to work effectively with fam-



ily members. An exception is pediatricians. Every pediatrician knows that he or she must work effectively, generally with the mother, in order to do the job. Pediatricians are trained to work with mothers to get information from them. Most other health professionals are "distrained." Third, in this country (as opposed to some European countries), we provide entitlements to individuals but do not do a very good job of supporting families. Doing a better job of supporting families may run the risk of eroding entitlement to the individual. I worry about that a lot. Families need help in providing care for a family member. In every family I have personally observed, no matter how concerned, how loving, how involved they were, if they had enough money, they had paid help. Taking care of another human being is really hard work.

**NJM:** That's right. No vacations and no holidays. In addition, there has been a population shift.

**Dr. Vladeck:** Yes. When people get too critical of long-term care in this country, I remind them that we are dealing with a set of circumstances that are unprecedented. Never before in human history have we had so many old people. We have never had so many old people with 70-year-old kids!

**NJM:** When you were at the New Jersey Department of Health, we had a highly regulated environment. It is certainly less regulated now. What do you see as the ideal?

**Dr. Vladeck:** I do not think that there is an ideal or optimal level. There is a tendency to alternate between too much and too little.

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When I was a regulator in New Jersey, the most enjoyable part of my job was the certificate-of-need program. I felt that we were shaping the future of health care, making decisions that made a difference. In retrospect, it was probably the least productive activity that we were engaged in. It is really hard to find a net social benefit.

On the other hand, with regard to quality, it is not enough simply to encourage quality improvement. We have learned two things in this regard. One is that the market is not going to put pressure on providers for quality measurement. We also learned that we can mandate a process of quality improvement, but we cannot mandate the outcomes.

At the same time, you cannot eliminate the regulatory floor. In fact, if you have good quality improvement activity in the provider community, you can raise the regulatory floor over time. We demonstrated that you can raise the proportion of people 65 and older who have received flu shots, you can

increase the number of two-year-olds who have been immunized, you can raise the proportion of post-MI patients who are on beta blockers. At some point, once you have demonstrated that, you can say that having 95% of two-year-olds immunized is no longer a target, it is a floor. In that way, there is a self-reinforcing cycle of improvement.

**NJM:** There has been a great deal of discussion in the press about the report of the Institute of Medicine regarding medical errors. What can be done in response, and at what level, to reduce or eliminate such errors?

**Dr. Vladeck:** It is clear that if the principles of industrial process engineering were rigorously applied to certain areas of medical practice and hospital administration, the rate of medical errors could be substantially reduced. A good example of this is the reduction in anesthesia-related mortality over the past 20 years, an extraordinary story. It was generated entirely within the profession, perhaps driven by medical liability concerns, but without explicit regulatory intervention. It's a revolution. But I'm not sure that you could apply the same principles to psychiatry or general medicine.

We really do not understand what it is about the patient-physician encounter that patients value, something that is very important to the patient. And there is some data suggesting that, for patients with certain kinds of problems, it is clinically important to the quality of the outcomes. Those interactions are probably less susceptible to industrial process engineering than anesthesia, for example. In some ways, physi-

cians may be similar to airline pilots, but in some important ways, they are not. If Boeing 737s started displaying as much variability in temperament as patients did, we would all be in a lot of trouble.

To respond to the Institute of Medicine report, we must determine which activities in hospitals, large group practices, and the health care system fit this model of industrial practice engineering. We must also determine which parts of the health care enterprise do not fit, so that we do not do damage by seeking to apply the wrong model.

Clearly, there is much to be gained in pharmacy by applying process engineering. Not only should we ensure that once the physician writes the script, the correct medication and the right dose are administered at the right time, we should also ensure that the prescribed medication is appropriate.

However, quality of care has much to do with the empathy of the provider, who makes an experience-based, partly intuitive, somewhat subjective assessment of the way a particular patient with a particular problem compares with the hundreds of other patients with the same or similar problem.

**NJM:** Could you tell us about the Institute for Medicare Practice and your role in it?

**Dr. Vladeck:** I have always been concerned about the distance between clinicians and those who make policy. This institution [Mount Sinai] has been particularly distinguished in geriatrics and has been concerned about public policy for a long time. The institute is a work in progress—or an experiment

in progress—about closing some of the gap between the clinical world and the policy world.

Our organizational theory is to place a group of policy people in the midst of a major academic medical center. Our basic operating style is that we function by collaboration. We keep a very small core staff, and everything we do is a joint activity with people who are more clinically involved. This is very comfortable for me, but it is not generally the way that an academic medical center works. We are working with our colleagues in geriatrics and general medicine, looking at problems in providing care to people, especially in the transition between the acute and postacute systems, in both directions. All of us on the staff are particularly concerned about the disparities in access and outcomes among different racial and socioeconomic groups. We identified this when we first started here nearly a year ago, and then the US surgeon general also identified it as a priority. The general theory is to bring the policy people and the clinicians

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together on issues that involve both sides.

We are involved in studying outcomes in hip fractures, and we want to see whether this could be adopted by HCFA as a standard. We are also working with our colleagues in home care and nursing to determine whether we can define an expanded role for a geriatric nurse practitioner in the management of home care. We would like to convert some of the practice of home care into science.

**NJM:** Is there anything else that you would like to say to our readers?

**Dr. Vladeck:** Sometimes it seems that the world is collapsing around us. Particularly for many clinicians, many things appear to be worse than they are, not just for them, but for their patients. The fact is, if you look at the data, the rate at which the health of the American people is improving is really quite phenomenal. It is not across the board—for example, it is not happening as fast among blacks as among whites—and that is very worrisome. But look at what is happening to the incidence of strokes; the rate has declined rapidly because of hypertension management and proper diets. Perhaps we could be doing even better, but notwithstanding that, the numbers are quite remarkable.

For example, the underlying long-term problem of Medicare and Social Security is that people are now living so long. It is important for physicians, many of whom feel so besieged all the time, to be reminded that the enterprise that they are engaged in has been incredibly productive. Physicians do not give themselves enough credit for what they have accomplished.



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# MANAGING PAIN: A DOCTOR-PATIENT CHALLENGE

*New Jersey Assemblywoman Charlotte Vandervalk*

**I**t might seem obvious that if pain can be reduced or eliminated it should be, but obtaining appropriate pain relief often does not happen, even when it is medically possible to do so.

According to the New Jersey Legislative Commission for the Study of Pain Management Policy, there are at least 19 steps [see sidebar] that need to be undertaken here in New Jersey, if we are going to be compassionate about pain. This legislative commission, which I chaired, consisted of physicians, nurses, patient advocates, and special consultants from the American Cancer Society.

The commission began by analyzing the many obstacles to pain relief. We held several public hearings and

heard a lot about fear. Physicians fear trouble with law enforcement for prescribing controlled substances, especially if they have a practice with a heavy caseload of patients with intractable pain. We heard a similar fear from pharmacists. Some patients are afraid that their supply of medicine will run out and so do not take the optimal dosage. Some patients simply do not complain of pain for fear of being considered weak or troublesome.

In its June 17, 1998 issue, *JAMA* reported a study showing that 26% of patients in nursing facilities with daily cancer pain receive no pain medication whatsoever, not even simple analgesics such as aspirin.<sup>1</sup> Dr. Jack Goldberg, representing the American Cancer Society, testified that 50% of patients with chronic

pain are not adequately relieved of pain. He also indicated that 95% of those patients could be pain-free with the standard medications that any doctor could prescribe. According to Dr. Richard Payne, professor of pain management at the University of Texas, pain is undertreated in as many as 46% of patients. Such needless suffering must be stopped. The issue of patient pain needs to be addressed comprehensively. A civilized society can do no less.

The commission recognized the serious and damaging conflict between law enforcement and physicians who prescribe extensive pain medications. A key recommendation was for the State Board of Medical Examiners to adopt the guidelines established by the



## Summary of Recommendations

### Public Recognition

1. The Commissioner of Health and Senior Services should issue a policy statement recognizing appropriate assessment, management, and treatment of pain as a significant public health concern.

### Education of Health Care Providers

2. Medical schools in New Jersey should be required to include a component on pain management in their curricula.
3. Health care professionals should be required to earn continuing education credits in pain management and interdisciplinary palliative care.

### Education of Health Care Consumers

4. The Commissioner of Health and Senior Services should establish a comprehensive multimedia public education campaign on pain management.
5. The Department of Health and Senior Services should identify and publicize the availability of pain management information referral services for the general public and health care providers.

### Professional Practice

6. The State Board of Medical Examiners should adopt the model guidelines of the Federation of State Medical Boards for the prescribing of controlled substances for pain control.

### Reducing Organizational Barriers

7. The Commissioner of Health and Senior Services should require that hospitals and long-term care facilities establish interdisciplinary pain management policy committees.
8. The Commissioner of Health and Senior Services should require

that these health care facilities provide for the monitoring of pain in their formal discharge protocols.

9. Legislation should be enacted . . . to amend the "bill of rights" for acute care hospital patients and nursing home residents in state law, and the Department of Health and Senior Services should revise the "bill of rights" for rehabilitation hospital patients in its administrative regulations, in order to provide these persons with the right to expect and receive appropriate assessment, management, and treatment of pain as an integral component of their care.

### Pain Monitoring

10. The State Board of Medical Examiners and the New Jersey Board of Nursing, as applicable, should require physicians, physician assistants, and nurses to regularly assess patient pain and record levels of pain intensity on patient charts as part of routine practice.
11. The Commissioner of Health and Senior Services should adopt regulations to provide for the monitoring of pain as a "fifth vital sign" in licensed health care facilities.

### Access to Pain Medications

12. Prescribers and pharmacists should seek to jointly develop improved methods for verifying the validity of prescriptions for pain medications and improving patient access to pain medications.
13. The New Jersey Board of Pharmacy should be required to maintain a current listing of all pharmacies that are open 24 hours a day and make this list available to the public.
14. Legislation should be enacted . . . to permit nurse practitioners/clinical nurse specialists and physician assistants to

order and prescribe controlled substances to patients in end-of-life situations or with terminal conditions under physician supervision.

### Reducing Insurance Barriers

15. The Department of Health and Senior Services should sponsor a pain management conference for health insurers, employers, business organizations, and labor on reducing insurance barriers to appropriate pain management.

### Research

16. Legislation should be enacted . . . to require that the New Jersey State Commission on Cancer Research encourage the development of research projects on pain management and palliative care for cancer patients.

### Alternative and Complementary Therapies

17. The Commissioner of Health and Senior Services should establish a mechanism to evaluate alternative and complementary pain management therapies and report its findings to the legislative health committees.

### Pain Management in Terminally Ill Patients

18. Hospitals and nursing homes should adopt pain management standards to meet the special needs of patients with terminal conditions, which may include acute pain management guidelines published by the US Agency for Health Care Policy and Research.

### Further Study of Pain Management Policy

19. An Advisory Council on Pain Management Policy should be established as a follow-up entity to this commission, to serve for a two-year period.

Federation of State Medical Boards of the United States.<sup>2</sup> If this occurs, physicians will have assurance that their licenses and reputations will not be at risk if they follow the guidelines in giving pain medications. It would indeed be a major step forward.

Another recommendation was for health care facilities to establish interdisciplinary, in-house pain management committees, so that all facility staff become active in formulating and implementing the policy on pain. The commission also recognized the importance of continuing medical education as it relates to pain practices and the need to establish courses on pain control in our medical schools.

Some of the commission's recommendations require legislation. Therefore, I have introduced a package of four such bills in the Assembly. The first, A-317, requires New Jersey's Commission on Cancer Research to encourage research on cancer pain management and palliative care.

The second measure, A-318, requires the Department of Health and Senior Services to establish the New Jersey Pain Management Policy Advisory Council, consisting of 21 mem-

bers. This would bring together experts to monitor the implementation of the initial Commission's 19 recommendations and provide expert ongoing analysis of pain-related issues.

A third bill, A-319, amends the existing Patient's Bill of Rights to provide hospital patients and nursing home residents with the right to expect and receive appropriate pain assessment, management, and treatment as an integral component of their care.

Perhaps the most far-reaching recommendation is to establish the monitoring of pain as a "fifth vital sign." Under A-316, a health care facility would be required to monitor pain as a fifth vital sign in patients. This means that when the health care provider checks the four vital signs, the patient should also be asked if he/she is in pain and would be asked to indicate the intensity of that pain on a personal scale of one to ten. Ten would be the worst pain that the patient could imagine. This would be recorded in the medical chart and be available for future comparison. This does not mean that one patient's pain would be compared with another's, but that the individual patient's "pain

progress" would be monitored and evaluated for appropriate treatment. This concept will be a future requirement by the Joint Commission on Accreditation of Healthcare Organizations.

Pain has many consequences in addition to the obvious suffering of the individual. It may result in unscheduled hospital admissions, excessive use of emergency rooms, family breakups, and even unemployment. The ultimate threat is suicide. The need for action is clear. Science has shown us how to eliminate pain. We would be barbaric if we did not do all that we can to alleviate this suffering.

*Charlotte Vandervalk has been a member of the NJ General Assembly since 1991, representing Legislative District 39. She is chairwoman of the Assembly Health Committee and the Commission for the Study of Pain Management Policy and a member of the Assembly Senior Issues and Community Services Committee.*

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# PHYSICIANS SPEAK OUT ON PHYSICIANS CONFERENCE 2000

THIS YEAR, NEW JERSEY IS BREAKING NEW GROUND WITH PHYSICIANS CONFERENCE 2000. IT WILL BE OUR FIRST STATEWIDE MEETING OF A UNIFIED PHYSICIAN COMMUNITY. IT ALSO MAY BE ONE OF THE LARGEST MEDICAL CONFERENCES IN THE COUNTRY. ALL LICENSED PHYSICIANS, MEDICAL STAFF, AND PHYSICIANS IN TRAINING ARE INVITED TO ATTEND.

*Robin Rapport*

**T**hirty-five medical specialty societies and related organizations have been involved in planning this extraordinary event. Attendance is expected to be very high. This unique conference is bound to have clinical and political implications throughout the medical community and far beyond. The following physicians shared their thoughts with us about the upcoming event:

- Stuart Cook, MD, president, University of Medicine and Dentistry of New Jersey.
- Stefan Epstein, MD, planning committee member and executive committee member, New Jersey Society of Pathologists.
- Palma Formica, MD, past president of MSNJ and Academy of

Medicine and former AMA trustee.

- Barnard Kaplan, MD, alternate MSNJ delegate, Camden County.
- Jerome Molitor, MD, vice speaker, House of Delegates.
- Joseph Reichman, MD, chairman, Physicians Conference 2000.
- Richard Sharrett, MD, MSNJ delegate, Union County.

## **What is the background leading up to the Physicians Conference?**

Dr. Reichman: As you know, physicians are under siege politically from managed care companies and really haven't been completely effective in making the changes we need to make in the health care system. We have many splinter groups of

physicians—the Medical Society, the specialty societies, and individuals—all trying to effect their own changes.

The concept behind the conference is unique. This conference is the only one in the country that is going to be open to *every* physician in the state. The underpinnings are threefold. First, there's a scientific agenda—so that each of the specialty societies can have an educational piece. Second, there's a political agenda—and that is to bring everyone together under one roof and for everyone to be on the same page. The third underpinning is the social aspect. That is getting to know each other, not just within the Medical Society but within other specialty societies and with other physicians in the state.



## What's your perspective on Physicians Conference 2000?

Dr. Kaplan: The conference opens up great opportunities for the specialties and for all of us to be together. It's a unique opportunity for education and networking. It's also important from a political perspective. The conference offers a chance to participate in the process and to strengthen the hand of the Medical Society.

Dr. Molitor: The emphasis and goal is to bring together as many doctors as possible throughout the state through their medical specialty societies and/or the Medical Society itself. It's a great opportunity for the medical profession to get together for educational programs, political input, and commercial exhibits. It will be in conjunction with the annual meeting of the House of Delegates of the Medical Society. This provides a new, fresh approach that I'm hoping will be very successful.

Dr. Formica: Historically, we used to do this many years ago. Various specialty societies would come together when the Medical Society met. It presented a time when people could share and meet their colleagues from all around the state. Times changed, and there

were few places in New Jersey that were big enough to hold us all. The new convention center in Atlantic City really afforded us this opportunity. It's time to try it again. We need to do this, and the specialty societies wanted it.

Dr. Cook: The university (UMDNJ) is happy to take part in it. There are a lot of issues facing physicians—both practitioners and academic—in this current environment of managed care and the Balanced Budget Amendment. It is very useful to have people of various clinical and academic backgrounds coming together. There will be exhibits, high-quality speakers, and a chance for people to interact both formally and informally. That can only be helpful to our patients and to clinical research.

THE CONCEPT BEHIND  
THE CONFERENCE IS  
UNIQUE. THIS  
CONFERENCE IS THE ONLY  
ONE IN THE COUNTRY  
THAT IS GOING TO BE  
OPEN TO EVERY PHYSICIAN  
IN THE STATE.

## What are some of the advantages of such an event?

Dr. Molitor: The idea is to expose as many physicians as possible to the various specialty societies and to the MSNJ. There will be big-name speakers and great opportunities for involvement.

Dr. Kaplan: There will be a lot of synergy in having doctors from various specialties at one conference. In the past, you had to be active in your state specialty society *and* in the Medical Society. This is a better use of everyone's time.

Dr. Epstein: I find it of interest because as a general pathologist I deal with everything, and I end up consulting with many other physicians and health care professions. It is useful for me to see what's going on clinically, to see what clinicians are being exposed to and how they react to it. It's hard to know how many others feel this way. It always is good, however, to see what is happening in other specialties, to know what the state of the art is, and to identify areas of overlap among various health care professionals and facilities.

Dr. Cook: By having all physicians represented, it leads to a better understanding of each other's problems and to better planning processes and outcomes.

## Do you see any disadvantages?

Dr. Kaplan: I cannot see any negatives to it. There are many incentives to attend. Plus, the specialty societies will also have better attendance at their own individual meetings.

Dr. Sharrett: While I had my doubts at first, the potential for a New Jersey State conference is exciting. If we unite medically and politically, as doctors and as citizens, we can make a greater impact.

Dr. Cook: Remember, the AMA was unsuccessful when it tried to speak with one voice. It is not all necessarily going to be translated into effective policies. But by discussing issues, trying to resolve problems, and coming up with consensus statements, it will certainly help.

## Why should physicians attend?

Dr. Formica: It is a good opportunity for doctors to get their CMEs and to keep abreast of what the specialty societies are doing. Doctors are torn in so many different directions. It will be nice to have everything so centrally located.

Dr. Cook: Several important agendas are occurring together. There is the political/legislative aspect. There's sharing of experiences such as dealing with managed care and dealing with specific disease states. There's educating physicians

## THE CONFERENCE OPENS UP GREAT OPPORTUNITIES FOR THE SPECIALTIES AND FOR ALL OF US TO BE TOGETHER. IT'S A UNIQUE OPPORTUNITY FOR EDUCATION AND NETWORKING.

about the latest advances, including nonpaper records, the Internet, electronic communications, and other continuing education. All of these things benefit the physicians, our patients, and even the New Jersey economy. It helps our patients get world-class care in New Jersey.

Dr. Epstein: It's important to see what's going on in other areas and to assess the levels of sophistication in care. Shared information will lead to better treatment.

## What effect will it have on policy making? On the medical legislative agenda?

Dr. Molitor: One way that we as physicians can help our patients is to make an impact on legislature. Presenting a united front will help everyone.

Dr. Formica: We are less effective when each specialty organization

tries to lobby for its own particular interest. We are here for the good of the patient. What harms the patient harms all of us. If we have a forum where we discuss the issues, it will have an impact. As physicians, we have to be politically astute, particularly today. So many of the managed care regulations affect us all. If we want any changes, we must speak with a unified voice. We are all out for the same thing—that our profession does not become a trade.

Dr. Kaplan: In the past, doctors' presence was not felt. Insurance companies, third-party payors, and others are powerful. They have taken advantage of the fact that doctors were not able to present a unified front.

Dr. Reichman: One of the things that happens in Trenton or in Washington is that one medical group will go to a group of senators with one position and another medical group will go to another group of senators with a another position. Imagine laypeople trying to understand what the position of the medical profession is on a particular issue. It is tough for them to make a decision on what to do politically when the medical profession is not united in presenting a uniform front.

Dr. Sharrett: As individual physicians, we are virtually powerless.



And unions make no sense for physicians—unless you are willing to strike. But if we unite medically and politically, as doctors and citizens, we can make a greater impact.

### **What value is it to members of MSNJ and, specifically, the specialties?**

Dr. Sharrett: There's a list of speakers that will knock your socks off. There are excellent medical seminars that cross many societies as well. Groups can share experiences from the point of view of medical education, managed care, and government. This can help turn things around and get membership up.

Dr. Epstein: It is good for specialties to learn what other specialties are doing. The chance to interact with other people (and to see what they are doing and how they are doing it) is important. It's also important to get updated on current technology and to expand your horizons.

Dr. Formica: We are less effective when each specialty society tries to lobby for its interest.

### **What is the role of the House of Delegates at the meeting?**

Dr. Molitor: In conjunction with the conference, we will be having our annual House of Delegates of the Medical Society of New Jersey meeting. The business of the House

at this meeting is to elect officers, delegates, and other positions. We will act on various resolutions that are being brought up by individuals or by component county societies. It's my hope that members who are not delegates or doctors who are not members of the Medical Society will want to sit in on our meeting. They may be interested in what's going on in the House of Delegates. I hope that they want to get involved.

### **Any last thoughts that you would like to share?**

Dr. Reichman: The conference is a nonthreatening way for people to get together. The goals are getting the physicians in New Jersey to recognize each other and to be more collegial; to understand each other's minor political differences; and to move forward with a real political agenda with some trust among our

peers and colleagues. I see this as an introductory meeting to get to know one another again and then to move forward to start problem solving together.

Dr. Sharrett: What I hope will come from the input of many societies is that, instead of becoming members of a union, doctors unite as professionals and resume care to patients.

Dr. Formica: The only way you can make changes is to be where policy is made. That's why it's so important to be involved. Whether it is in political action or advising the state department of health, somebody has to speak for the voiceless. And most of the voiceless are our patients. They are the ones being affected. To have to fight to be able to treat a patient the way that patient needs to be treated medically is an outrage . . . I am looking forward to this conference. It will give us a chance to come together.

Dr. Molitor: We're hoping as many people as possible will come. Anything less will be a lost opportunity.

Dr. Kaplan: I am hopeful that this will have impact. Changes will happen. Physicians do not need to feel powerless!

*Robin Rapport is a freelance writer based in Trenton.*

**WE ARE HERE FOR THE  
GOOD OF THE PATIENT.  
WHAT HARMS THE  
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# COLLABORATION EFFORTS AMONG PHYSICIANS AND OFFICE STAFF: A PHYSICIANS CONFERENCE 2000 GOAL

*Robin Rapport*

Every doctor knows how important it is to have a smoothly running office. In today's health care environment, a collaborative relationship between physicians and their staffs has never been so important. Regulatory issues, compliance issues, and legal issues are just a few of the reasons why it is so critical for medical office managers, assistants, staff, and physicians to work together.

Physicians Conference 2000 offers an opportunity for both education and collaboration. "The Physicians Conference 2000 takes into account the office staff's role in running a medical office. The physicians and medical staffs are in this together. Increased knowledge, better efficiency, and partnership will benefit everyone," says Joanne Calabrese, a past president of the New Jersey Society of Medical Assistants (NJSMA), who is also involved with the Medical Group

Management Association (MGMA) and the conference.

The various professional organizations for medical office personnel support Physicians Conference 2000. Two of them, MGMA and NJSMA, have signed on to help develop the conference.

MGMA is the leading organization representing medical group practices nationwide. MGMA includes 8,300 health care organizations and more than 21,000 individuals, representing more than 209,000 physicians. "In New Jersey, we have at least 250 members representing offices of various sizes," says Ed Ludwig, past president of MGMA.

The main purpose of MGMA is "to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them," says Ludwig. MGMA's core values include supporting delivery of patient-focused care and using the group practice as a framework for

superior delivery of care. Since its inception, MGMA has facilitated the exchange of ideas with other assemblies and societies facing similar challenges and responsibilities in the medical profession.

Likewise, NJSMA works toward a collaborative approach. NJSMA and its national organization, the American Association of Medical Assistants (AAMA), consist of practicing medical assistants (administrative, clinical, office managers), medical assisting educators, students, and others (including physicians). "There are more than 1,000 members in the state of New Jersey," says Betty Springer, president of NJMSA. "Medical assistants are a major part of health care services today. Physicians and patients rely on them for integral administrative and clinical duties."

With values that include teamwork, inclusion, patient-focused care, and efficiency, it is no wonder that organizations devoted to medical office staffs, management, and



education are drawn to Physicians Conference 2000. "We look at Physicians Conference 2000 as a chance to interact with the medical community and go over common problems," says Ludwig. "Everyone in medicine is in the same boat. No matter what area of practice we are in, we all have to deal with personnel issues, state regulations, compliance programs (including the law, audits, and other issues), and Medicare."

### The Value of Office Staff at a Physicians Conference

Having an annual medical conference that includes office staff is an empowering opportunity for staff, managers, and physicians to work together in a better partnership. Office staff can attend any of the II programs especially for them. They also may go to any clinical program, plenary session, or other activity. Similarly, physicians may attend any session as well.

Crossover is anticipated. "For example, physicians and staff alike need to understand the legal aspects of our work. We are all particularly excited about the Saturday morning mock trial (*Physician on Trial*), as well as the legal, regulatory, and other programs, such as *Death and Dying* and *Preparing for a State Medical Board Visit*," Calabrese says. Ludwig adds that hot topics include medical compliance issues, particularly since the Office of the Inspector General wants to increase the compliance levels for

medical offices to approach levels closer to that in hospitals.

The benefits of Physicians Conference 2000 for office management and staff include the credits to maintain certification, networking opportunities, and all the advantages that come from office staff, managers, and physicians attending the same conference. "At a time when every organization is struggling for attendance, financial support, and excellent speakers, it will be great to have all the groups together," says Calabrese.

"Another advantage will be the accessibility of vendors. In the past, our conference had about 20 exhibitors, total. Now, our members will have the opportunity to see more exhibits. They can see 15 computer vendors, instead of just two," notes Ludwig. "And by having our own MGMA booth, we will be able

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talk to the physicians. We'd like to let doctors know what we're about and how we can help them. We also have an extensive database with job descriptions, salaries, and other information that could be an invaluable resource for doctors," says Ludwig.

"It is hoped that physicians will recognize the value of continuing education for their staff," says Springer. "The bottom line is that if the people working for you are more educated, they are more valuable to your practice. For example, in the medical/legal area, knowledgeable medical assistants can help reduce a physician's liability exposure. They're the ones closest to patients." Springer explains, "An educated staff is a long-term gain."

### A Groundbreaking Conference

Ludwig and others are excited about Physicians Conference 2000 because of the educational experience it offers and the unity it can forge among the medical community, and office and administrative personnel. He hopes the conference will become "one of the premier meetings in the country."

Calabrese observes a final, important—though unintended—benefit for office managers and staff, "For one thing, it is easier to ask your boss to attend a conference that he or she is also going to attend."

Robin Rapport is a freelance writer based in Trenton.



# Physicians Conference 2000

*Advancing the Practice*

## WORKSHOPS & PROGRAMS

*"Advancing the Practice" involves learning more about the range of issues facing physicians, medical office staff and allied health professionals ... from asthma to vaccines and from politics in the medical office to those found in Trenton and Washington D.C. Review the following list of programs, workshops and lectures to start planning your time in Atlantic City at the exciting Physicians Conference 2000.*

### Thursday, May 4

|                                       | 7 <sup>AM</sup> | 8 | 9 | 10            | 11 | 12 <sup>PM</sup> | 1 | 2                      | 3 | 4 | 5 |
|---------------------------------------|-----------------|---|---|---------------|----|------------------|---|------------------------|---|---|---|
| MSNJ House of Delegates               |                 |   |   | First Session |    |                  |   |                        |   |   |   |
| MSNJ Golden Merit Awards and Luncheon |                 |   |   |               |    |                  |   |                        |   |   |   |
| MSNJ Reference Committees             |                 |   |   |               |    |                  |   | A-1:30; B-2:15; C-3:00 |   |   |   |
| AFP House of Delegates                |                 |   |   |               |    |                  |   |                        |   |   |   |



# Friday, May 5

## SESSION I: 8:15 - 9:15 AM

1. Interactive Health Communications: *Using New Media to Reach Patients* – Victor Strecher, PhD

## SESSION II: 9:30 - 11:00 AM

2. *How to Assure Competence: Is Credentialing the Answer?* – Panel discussion comprising representatives from AMAP, JCAHO & NCQA – Moderator, Stefan E. Epstein, MD
3. *Warning: Managed Care May Be Dangerous to a Physician's Health* – John P. Docherty, MD
4. *The Demise of the Volunteer Medical Staff* – Todd C. Brower, Esq & John D. Fanburg, Esq, Brach, Eichler, Rosenberg, Silver, Bernstein, Hammer & Gladstone
5. *Conscious Sedation: Update 2000* – Thomas W. Cutter, MD
6. *The Evaluation of the Patient With Medical or Surgical Breast Symptoms* – Panel Discussion - Primary Care – Randi Protter, MD; Radiology – Susan Greenstein Orel, MD; Surgery – Nancy Elliott, MD; Pathology – TBD

### OFFICE STAFF

7. *Regulatory Mania in the New Millennium* – Denise Saunders, Esq, Kern Augustine Conroy & Schoppmann, P.C.
8. *Preparing for a State Medical Board Visit* – Robert Conroy, Esq, Kern Augustine Conroy & Schoppmann, P.C.

## PLENARY SESSION

11:00 AM – 12:30 PM

**WELCOME/KEYNOTE: DR. BOB ARNOT**  
**"Effect of Media on Patient Behavior"**

## SESSION III: 1:30 - 3:00 PM

9. *Psychopharmacology: What's New & Designer Drugs* – John P. Docherty, MD

10. *Type 2 Diabetes – New Technologies* – TBD
11. *Allergy and Asthma Update: The End of Sneezing and Wheezing* – Michael Kaliner, MD
12. *The Future of Physician Organizations* – Burton Eichler, Esq., Joseph M. Gorrell, Esq., Susan Y. Leonard, Esq., Brach, Eichler, Rosenberg, Silver, Bernstein, Hammer & Gladstone
13. *Pregnancy, Pediatrics & HIV Infection: Guidelines for Your Practice* – Arlene D. Bardeguez, MD & George D. McSherry, MD
14. *Women's Health Issues: Recognition and Treatment* – Gerson Weiss, MD
15. *Death & Dying: Easing the Pain* – Panel Discussion: Susan M. Bauman, MD; Teresa M. Schaer, MD; Paul Armstrong, Esq
16. *Pneumococcal Infection: A Disease in Need of Prevention* – Mark I. Zimmerman, MD

### OFFICE STAFF

17. *Learning How to Play Well In The Sandbox* – Steven Kern, Esq, Kern Augustine Conroy & Schoppmann, P.C.
18. *Medicare Reimbursement – What is New One Year Later* – Gail Rounds

## SESSION IV: 3:30 - 5:00 PM

19. *Hepatitis C & HIV Co-Infection* – UMDNJ-AIDS Education & Training Center – Douglas Dietrich, MD
20. *Advances in the Evaluation and Management of Sleep Disorders* – Karl Doghramji, MD
21. *Rheumatoid Arthritis: It Shouldn't Hurt to Move* – Elliot Rosenstein, MD
22. *Therapeutic Options for the Patient in Chronic Pain* – Panel Discussion - Physical Medicine & Rehabilitation – Lauren Shaiova, MD; Psychiatry – Thomas Newmark, MD; Anesthesiology – John Secoy, MD

### OFFICE STAFF

23. *OSHA & Medical Waste Technologies* – John LaCarrubba
24. *Fraud and Abuse* – Michael Schoppman, Esq, Kern Augustine Conroy & Schoppmann, P.C.
25. **Physicians Public Affairs Seminar,**  
**Featuring NJ Legislative Leadership 3:30 – 5:00 PM**

# Friday, May 5

|                                        | 7 AM | 8       | 9              | 10 | 11 | 12 PM | 1 | 2 | 3 | 4 | 5 |
|----------------------------------------|------|---------|----------------|----|----|-------|---|---|---|---|---|
| MSNJ House of Delegates                |      |         | Second Session |    |    |       |   |   |   |   |   |
| Registration                           |      | All Day |                |    |    |       |   |   |   |   |   |
| Exhibits Grand Opening                 |      |         | Exhibits Open  |    |    |       |   |   |   |   |   |
| Plenary Session: Dr. Bob Arnot         |      |         |                |    |    |       |   |   |   |   |   |
| Breaks, Lunch provided in Exhibit Hall |      |         |                |    |    |       |   |   |   |   |   |
| Workshop Session 1 & 2                 |      |         |                |    |    |       |   |   |   |   |   |
| Workshop Session 3                     |      |         |                |    |    |       |   |   |   |   |   |
| Workshop Session 4                     |      |         |                |    |    |       |   |   |   |   |   |
| Physicians Public Affairs Seminar      |      |         |                |    |    |       |   |   |   |   |   |
| Reception in Exhibit Hall              |      |         |                |    |    |       |   |   |   |   |   |



# Saturday, May 6

## SESSION V: 8:00 - 9:30 AM

- 26. *New Technologies Part I: Ultrafast CT & Cardiac Risk Reduction* – Louis Teicholtz, MD; Telemedicine – John Brennan, MD
- 27. *Eyes 101: Basic Ophthalmology for the Primary Care Provider*
- 28. *Herbal Medicine Interactions with Anesthesia* – John B. Neeld, Jr, MD, President, ASA
- 29. *Update in Pediatric Cardiology: Life Without 4 chambers* – Milton Prystowsky, MD
- 30. *Treating the Gay and Lesbian Patient* – Tom Ziering, MD
- 31. *Association of BV & HIV* – Hugh Watts Randall, Jr, MD
- 32. *Alzheimer's Disease: Slow but Steady Progress* – Stanley Birge, MD
- 33. *Why we Get Sick: The New Science of Darwinian Medicine and Psychiatry* – Randolph Nesse, MD
- 34. *Treating Respiratory Infections in the Age of Resistance* – John W. Sensakovic, MD, PhD, President, AMNJ
- 35. *Prenatal Testing for Endocrine Disorders* – Louis C. Haenel, DO
- 36. *State of the State in Cardiac Surgery* – Alan J. Spotnitz, MD
- 37. *Urinary Incontinence* – Rodney A. Appell, MD

## SESSION VI: 9:30 - 11:00 AM

- 38. *New Technologies Part II – Imaging Technology – "The Critical Role of Positron Emission Tomography (PET) in Modern Oncology*, Abass Alavi, MD; *Laser Refractive Surgery* – TBD; *Chest CT for Smokers* – Mark Paul Bramwit, MD & Judith K. Amorosa, MD
- 39. *Sexual Harassment in the Workplace: The Trial of a Sexual Harassment Case* – Edward Ellis, Esq , Montgomery, McCracken, Walker & Rhoads, LLP
- 40. *Pediatric Myths, Misnomers and Controversies* – Michael J. Gerardi, MD & Alfred D. Sacchetti, MD

- 41. *Epilepsy: New Medications and Surgical Techniques* – David M. Treiman, MD
- 42. *35 Ways to Improve Your Office Efficiency Right Now* – Joseph S. Eastern, MD
- 43. *Plastic & Reconstructive Surgery* – TBD
- 44. *Primary Management of Ocular Emergencies* – TBD
- 45. *PM&R Billing & Coding* – Elaine Caruso
- 46. *Advances in Spinal Surgery: New Treatment Methods for Osteoporotic Compression Fractures* - Kenneth J. Kopacz, MD; *Artificial Disc Replacements* - Casey K. Lee, MD; *Laser Discectomy* - Marc I. Malberg, MD
- 47. *MR Angiography of the Abdomen & Extremities* – James P. Earls, MD
- 48. *Hospitalist: More Efficient Patient Care or the End of the Physician Patient Relationship* - TBD
- 49. *Urinary Incontinence* - TBD

## PHYSICIANS IN TRAINING

- 50. *Procedures for Physicians in Training*
- 51. *The Next Step-Job Search*

# PLENARY SESSION

11:00 AM - 12:30 PM

KEYNOTE: RICHARD PRESTON, Ph.D.  
"The Cobra Event:  
On The Trail of Biological Terrorism"

# Saturday, May 6

|                                                   | 7 AM | 8                                | 9             | 10 | 11 | 12 PM | 1 | 2 | 3 | 4 | 5 |  |
|---------------------------------------------------|------|----------------------------------|---------------|----|----|-------|---|---|---|---|---|--|
| MSNJ House of Delegates                           |      |                                  | Third Session |    |    |       |   |   |   |   |   |  |
| Exhibit Hall & Registration Open                  |      | Exhibit Hall & Registration Open |               |    |    |       |   |   |   |   |   |  |
| Breakfast, Breaks, Lunch provided in Exhibit Hall |      |                                  |               |    |    |       |   |   |   |   |   |  |
| Workshop Session 5                                |      |                                  |               |    |    |       |   |   |   |   |   |  |
| Workshop Session 6                                |      |                                  |               |    |    |       |   |   |   |   |   |  |
| Plenary Session: Richard Preston, Ph.D.           |      |                                  |               |    |    |       |   |   |   |   |   |  |
| Physicians in Training Luncheon                   |      |                                  |               |    |    |       |   |   |   |   |   |  |
| Job Fair in Exhibit Hall                          |      |                                  |               |    |    |       |   |   |   |   |   |  |
| Workshop Session 7                                |      |                                  |               |    |    |       |   |   |   |   |   |  |
| Academy of Medicine of New Jersey Lecture         |      |                                  |               |    |    |       |   |   |   |   |   |  |
| MSNJ Presidential Gala (7:00 PM)                  |      |                                  |               |    |    |       |   |   |   |   |   |  |



# Sunday, May 7

## SESSION VII: 1:30 - 3:00 PM

52. *Complementary Medicine: Voodoo or Unrecognized Science* – Jay Kaplan, MD
53. *Physician on Trial* – Anthony Caggiano, MD
54. *Advances in Prostate Surgery* – Louis Keeler, III, MD
55. *Endoscopic Sinus Surgery from Anatomy to Ethmoidectomy to Advances in Frontal Sinus Surgery: 25 Years of Observation* Steven Shaeffer, MD
56. *Clinical Update: Advances in the Diagnosis and Treatment of Osteoporosis* – Jeffrey Levine, MD
57. *Genetics – A New Frontier* – Ronald Wapner, MD
58. *Pediatric Dermatology* – Bernard A. Cohen, MD
59. *Transplantation: Up and Coming New Advances* – Dorian J. Wilson, MD
60. *Headache: Diagnosis and Treatment* - Loretta Mueller, DO
61. *Staying Alive with Tachycardia* – Steven Winters, MD
62. *Documentation Guidelines for PM&R* – Toni Revel
63. *New Approaches to the Management of Adult and Pediatric Patients with Attention Deficit Disorder* – TBD

### PHYSICIANS IN TRAINING

64. *Musculoskeletal Exams and Joint Aspiration*
65. *Health Informatics*
66. **Academy of Medicine of New Jersey Lecture**  
Christine M. Grant, JD, MBA, Commissioner,  
NJ Department of Health and Senior Services

## SESSION VIII: 9:00 - 10:30 AM

67. *SnoMed – Systematized Nomenclature of Human MEDicine* - TBD
68. *Addiction Medicine* - Louis Baxter, MD, MSNJ Physician's Health Program
69. *Negotiating with Managed Care* – Katherine Benesch, Esq., Archer & Greiner
70. *Menopause and Depression* –Philip T. Ninan, MD & Hilda B. Templeton, MD
71. *Adult and Pediatric Immunization: What's New?* – William Atkinson, MD, MPH, Medical Epidemiologist, CDC
72. *Clinical Trials – Where Does NJ Stand in the National Health Care Quality Improvement Clinical Priority Topic Areas* – Thomas Blumenfeld, MD & Joseph Spagnuolo, MD
73. *Black Infant Mortality* – TBD
74. *New Advances in Bloodless Medicine & Surgery* – Aryeh Shander, MD
75. *Cancer Genetics Education for Health Care Professionals* – Deborah Lynn Toppmeyer, MD

## PLENARY SESSION

10:30 AM – 11:30 AM

**KEYNOTE: REP. GREG GANSKE, MD (Iowa),**  
Leading physician member of Congress

# Sunday, May 7

|                                             | 7 AM | 8             | 9 | 10 | 11 | 12 PM | 1 | 2 | 3 | 4 | 5 |
|---------------------------------------------|------|---------------|---|----|----|-------|---|---|---|---|---|
| Exhibits Open                               |      | Exhibits Open |   |    |    |       |   |   |   |   |   |
| Continental Breakfast and Break             |      |               |   |    |    |       |   |   |   |   |   |
| Workshop Session 8                          |      |               |   |    |    |       |   |   |   |   |   |
| Plenary Session: U.S. Rep. Greg Ganske, MD. |      |               |   |    |    |       |   |   |   |   |   |

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# PHYSICIANS CONFERENCE 2000 REGISTRATION FORM

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**Status:**☐ Physicians☐ Physician in Training (Resident)\*\*Written verification required by Program DirectorAffiliation☐ Office StaffPractice Name☐ Medical Student\*\*Written verification required by Program DirectorSchool Name☐ Allied Health Professional (i.e. nurse, technician, physician's assistant, etc.)☐ Other**Memberships:** (please check or complete all that apply)☐ Medical Society of New Jersey☐ The Academy of Medicine of New Jersey☐ Societies: (See Page 9 for Society Code Numbers)Society CodeSociety CodeSociety Code(Other Organizations(s) not listed)

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Credentials (For Example: MD, DO, etc.) \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Office Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Office Fax \_\_\_\_\_ email \_\_\_\_\_

Spouse/Guest Name: \_\_\_\_\_

(As it will appear on badge)**Convention Registration Fees**

Physicians .....\$199.00

**Physicians Early Registration .....175.00**(postmarked by 4/10/00)

Office Staff Member.....99.00

**Office Staff Member Early Registration .....80.00**(postmarked by 4/10/00)

Allied Health Professional .....175.00

Other .....250.00

Physician-in-Training .....No Fee

Medical Students .....No Fee

MSNJA Member, Spouse/Guest.....50.00

**Social Activities:**

MSNJ Presidential Gala (Sat., 5/6/00) .....70.00/person

(Black Tie Affair - Open to all Attendees)

A Day in Cape May.....52.00/person

Boardwalk 5K Fun Run/2K Fitness Walk... ..25.00/person

**Specialty Events:**

NJAFP Presidents Dinner (Fri., 5/5/00) .....70.00/person

(Black Tie Optional - Open to all Attendees)

MSNJA President's Luncheon (Fri, 5/5/00).....35.00/person

**Pre-Registration Summary**

Registration Fee (from left)

MSNJA Member, Spouse/Guest Fee

Sat. (5/6/00) MSNJ Presidential Gala

A Day in Cape May

Fun Run/Walk

Fri. (5/5/00) NJAFP Presidents Dinner

Fri. (5/5/00) MSNJA President's Luncheon

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## PHYSICIANS CONFERENCE SOCIETY CODES

- 101 Association for Hospital Medical Education of New Jersey
- 102 Dermatological Society of New Jersey
- 103 Electrodiagnostic Medicine Association of New Jersey
- 104 Medical Society of New Jersey Alliance
- 105 Nephrology Society of New Jersey
- 106 Neurological Association of New Jersey
- 107 New Jersey Academy of Family Physicians
- 108 New Jersey Academy of Ophthalmology
- 109 New Jersey Academy of Otolaryngology - Head & Neck Surgery
- 110 New Jersey Association of Ambulatory Surgical Centers
- 111 New Jersey Chapter, American Academy of Pediatrics
- 112 New Jersey Chapter, American College of Cardiology
- 113 New Jersey Chapter, American College of Emergency Physicians
- 114 New Jersey Chapter, the American Society of Addiction Medicine
- 115 New Jersey Chapter, American College of Physicians/American Society of Internal Medicine
- 116 New Jersey Gastroenterological Society
- 117 New Jersey Medical Directors Association
- 118 New Jersey Medical Group Management Association
- 119 New Jersey Obstetrical and Gynecological Society
- 120 New Jersey Orthopaedic Society
- 121 New Jersey Pediatric Society
- 122 New Jersey Psychiatric Association
- 123 New Jersey Society for Gastrointestinal Endoscopy
- 124 New Jersey Society of Medical Assistants
- 125 New Jersey Society of Pathologists
- 126 New Jersey Society of Physical Medicine and Rehabilitation
- 127 New Jersey Society of Plastic Surgeons
- 128 New Jersey Society of Thoracic Surgeons
- 129 New Jersey State Society of Anesthesiologists
- 130 Radiological Society of New Jersey
- 131 The Oncology Society of New Jersey
- 132 The Urology Society of New Jersey
- 133 The Vascular Society of New Jersey





# PHYSICIANS CONFERENCE 2000

## ATTENDEE HOUSING INFORMATION

### GET YOUR ROOM EARLY!

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Please make your reservations by mail with the Reservation Request Form.

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**ATLANTIC CITY CONVENTION & VISITORS AUTHORITY  
HOUSING DEPARTMENT  
2314 PACIFIC AVENUE, ATLANTIC CITY, NJ 08401  
FAX: (609) 348-0025**

If all your choices are sold out, a property of comparable quality, price and location will be selected by the Housing Dept. based on availability. The Housing Dept. will send you an "acknowledgement" of your hotel assignment. Confirmations and deposits will be handled directly with the hotel and the guest.

**RESERVE EARLY:** All properties will adhere to a cutoff date of 30 days prior to the Conference. Reservations received after April 7, 2000 will not be guaranteed at the Convention rate. Changes or cancellations are to be made directly with the Atlantic City Convention Authority Housing Dept. in writing.

This listing is for information only and does not imply Physician Conference endorsement. The rates listed are subject to a maximum of 12% room tax and a tourism promotion fee (\$2 per night for casino hotel rooms and \$1 per night for non-casino hotel rooms) on each occupied room.

### CASINO & NON-CASINO HOTELS

#### CASINO HOTELS

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RATE: \$

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# PHYSICIANS CONFERENCE 2000 ATTENDEE HOUSING

## Hotel Reservation Form

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**Atlantic City Convention & Visitors Authority**

Housing Department

2314 Pacific Avenue

Atlantic City, NJ 08401

Fax: 609-348-0025

Please reserve the following:

**TEL:**

Choice: \_\_\_\_\_

Choice: \_\_\_\_\_

Choice: \_\_\_\_\_

**OCCUPANCY INFORMATION:**

Arrival Date: \_\_\_\_\_ Departure Date: \_\_\_\_\_

**CREDIT CARD INFORMATION:**

Credit Card: ☐ American Express ☐ Discover ☐ MasterCard ☐ Visa

Card No.: \_\_\_\_\_ Exp. Date \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

Cardholder's Name (please print name on card): \_\_\_\_\_

**ROOMS WILL BE OCCUPIED BY:** (Names **MUST** be supplied for each room reserved)

Names of Occupants

Street Address

City

State

Zip

**YOUR NAME** (please print):

Organization Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

### TYPE OF ACCOMMODATIONS:

\_\_\_\_\_ Single(s) for \_\_\_\_\_ person(s)

\_\_\_\_\_ Double(s) for \_\_\_\_\_ person(s)

Number of rooms requested: \_\_\_\_\_

☐ Non-Smoking ☐ Smoking ☐ Handicapped

**SPECIAL REQUESTS:** \_\_\_\_\_

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# NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS

## CONFERENCE ON PHYSICIAN EDUCATION

*On January 20, 2000, New Jersey's Board of Medical Examiners held an informal hearing, or conference, led by its president, Gregory J. Rokosz, DO, JD, and Mark S. Herr, director of the Division of Consumer Affairs.*

*The session addressed three regulatory issues that the Board has resolved to face: Should three years of postgraduate training be required of all physicians before licensure? Should continuing education be mandatory for all licensed physicians? Should the Board develop a personalized medical education alternative to disciplinary action for physicians with knowledge deficits?*

*The Medical Society of New Jersey participated actively in the day's events. Reproduced here is the testimony of the first speaker at the hearing. As president of MSNJ, Irving Ratner, MD, presented the organization's initial responses to the three issues and to multiple questions that the Board had raised regarding each issue. An ad hoc committee had helped Dr. Ratner develop these responses.*

**G**ood morning. My name is Irving P. Ratner, MD, and I am the president of the Medical Society of New Jersey, the largest physician organization in the state. I am also a practicing physician, board certified in orthopedic surgery.

I welcome the opportunity to share the viewpoints of the Medical Society of New Jersey concerning the three proposals on physician education that will be discussed this morning. But first I would like to commend Dr. Rokosz, Dr. Robins, and the other members of the Board of Medical Examiners for their forward thinking and bold action. The practice of medicine is certainly one of the most demanding professions, requiring a high level of knowledge that must be constantly refreshed. We applaud your efforts to improve the initial training standards for physicians in New Jersey and your commitment to the life-long learning process. We are especially impressed with the proposal that will establish an alternative personalized education program for physicians who have been deemed substandard from a clinical perspective.

I will provide comments on each of the three education proposals in the order that they were raised. I will also address the subpoints the Board has identified under each topic, which, I might add, were helpful in stimulating our thought process.

Since discussions involving these proposals will continue in the future, I offer the assistance of the Medical Society as you continue to develop these themes.

### Postgraduate Training

- We agree that the current one-year residency licensure requirement should be extended to two years. While we recognize that many medical specialty-training programs require three or more years of postgraduate training, a three-year residency requirement may be excessive for those physicians who choose not to specialize or work in a hospital setting.
- We believe that the development of the postgraduate training curriculum should be under the purview of the training program director. The training event should be tailored to the needs of the resident without the imposition of an overarching set of very specific mandated guidelines.
- The issue of "moonlighting" is controversial and should be balanced with the realities facing young physicians. We favor an approach that includes supervi-



sion of this activity through the residency program. That is, any outside employment must be known to and approved by the residency program. Consideration must be given to the resident's ability to handle the additional workload without adversely affecting clinical performance. In all cases, we believe the attending physician is responsible for the resident's conduct.

- The Board should consider a grandfather clause so that this new postgraduate training requirement affects only those individuals entering a residency program after the legislation is enacted. We suggest that the effective date should be the second July 1st after the legislation has been enacted. This date would coincide with the June medical school graduation date and provide at least a full year's notice to any graduating medical student.

### Continuing Medical Education

- There is no question that continuing medical education is vital to maintaining high-quality medical care. Both the American Medical Association and the Medical Society of New Jersey have strongly encouraged our physician members to obtain 150

hours of continuing medical education within a three-year period. Acute care hospitals in our state have a similar requirement that must be met before admitting privileges are granted to physicians. Managed care companies and many IPAs follow this approach as well. We support the continuing medical education licensure requirement for physicians and podiatrists, an action that has been adopted in 36 areas throughout the country. We encourage the Board to work closely with the Medical Society of New Jersey, the New Jersey Association of Osteopathic Physicians and Surgeons, the

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Academy of Medicine of New Jersey, and the New Jersey Podiatric Medical Society to define the appropriate number of continuing medical education hours that should be achieved and the time frame for obtaining those hours.

- Organizations accredited to provide continuing medical education courses conduct a need assessment as part of their planning process. The resulting educational programs are therefore designed to satisfy a specific training need. As clinical practice changes over time, so does the training curriculum. We would discourage the Board from becoming overly prescriptive in this area by mandating specific subject areas such as AIDS, family violence, pain management, medical ethics, physician-patient communication, confidentiality, prescribing practices, etc. Although these issues are certainly important and reflect the Medical Society's own priorities, they are topical at the moment and may not be the most appropriate courses for physicians in all specialty areas. The Board should refrain from mandating specific courses, except for courses that have been demonstrated to improve physicians' clinical

behaviors, meet the highest standards for quality continuing medical education, including justification through a formal needs assessment process, and apply to physicians universally. Even then, mandatory course work should consume only a small portion of the licensee's total continuing medical education requirement. Presumably, a similar mechanism can be used for the other health professionals that fall under the Board's jurisdiction.

- The national Accrediting Council of Continuing Medical Education (ACCME) in conjunction with the American Medical Association, the Academy of Medicine, and the Medical Society of New Jersey have developed a well-defined set of educational principles governing continuing medical education. These guidelines can easily be adapted to any initiative undertaken by the Board, designating an appropriate mix of Category I and II learning activities. Again, we encourage the Board to adopt flexible standards that allow for an educational process that meets the needs of individual physicians. The standards should also allow for new educational venues such as dis-

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tance learning now made possible through computer technology.

- We hope that the Board will use the continuing medical education system that is already in place; there is no need to reinvent the wheel. Both the American Medical Association and the Medical Society of New Jersey grant the Physician Recognition Award to individuals

who have completed the recommended continuing medical education coursework. This award program could be easily adapted to satisfy new requirements promulgated by the Board.

- Physicians self-report the completion of continuing medical education credits based on the honor system. We have found physicians to be forthright when submitting this information. We would caution against a system that is overly dependent on requiring the submission of extensive documentation coupled with random audits. Since there is an emphasis on self-directed learning in continuing medical education today, providing traditional forms of documentation may be difficult at best. However, if the Medical Society can help the Board ensure compliance, we will be glad to explore methods of cooperation.
- One example of nontraditional learning that I mentioned previously is distance learning. Along with the phenomenal growth of the Internet, there have been new developments in education. Distance learning now makes continuing medical education courses available on the Internet to be viewed by physicians at their convenience. This is an exciting



concept that fits nicely with a physician's busy schedule and doesn't require expensive, time-consuming travel historically associated with continuing medical education programs. Enduring materials, which use a variety of the communications media, provide an interesting opportunity as well. There are many other nontraditional approaches that can be considered, which can be delineated by the organizations that I have mentioned before.

### Personalized Education Program

- I would like to raise the example of the Physician's Health Program, administered by the Medical Society, which has been successful in providing treatment services to physicians who are suffering from addiction or mental health problems. The program's success is due in part to its rehabilitative approach in addressing the difficulties faced by the identified physicians. It truly provides the Board with an alternative to more punitive measures. We would recommend that the Personalized Education Program operate in a similar fashion so physicians view it as being remedial in nature.
- The Board should promote the Personalized Education Program

as a clinical improvement tool available to those physicians who have displayed possible deficits in their clinical skills. The goal is to offer physicians a focused remedial education plan geared toward improving their level of clinical functioning. The focus should be on training, which allows the physician to meet relevant quality-of-care standards.

- We think the Board can play a vital role in identifying and referring physicians whose clinical judgment may be in question. Once a referral is made however, the assessment and development of a focused reme-

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dial education plan should be designed by an independent organization. The Board should be apprised of the licensee's progress while involved in the learning process. But there must be a distinct separation between the Board and the organization operating the program so there is no mistake about the program's intent.

- Sometimes, requiring an assessment of a physician's clinical skills who has been out of practice for a period of time may make sense. In other circumstances, a hiatus from actual clinical practice may not indicate a problem. What about the circumstance, perhaps known in New Jersey, whereby a physician employed by a pharmaceutical company is performing research? The physician may deserve a medical license, but his or her clinical skills are not germane in this instance. We think that this issue should be studied more carefully before a judgment is made.

That concludes my remarks. I would be willing to entertain any questions the Board may have at this time. Again I offer the assistance of the Medical Society of New Jersey to help you in the implementation of these three initiatives.

# HIV DISEASE SURVEILLANCE: MEDICINE AND PUBLIC HEALTH WORKING TOGETHER

PUBLIC HEALTH SURVEILLANCE IS CRITICAL TO THE MANAGEMENT OF THE HIV EPIDEMIC. SURVEILLANCE HELPS TO DEFINE CHANGING TRENDS, FORMULATE AND STRATEGICALLY IMPLEMENT PREVENTIVE INITIATIVES, AND EVALUATE THE EFFECTIVENESS OF INTERVENTIONS. COLLABORATION BETWEEN CLINICAL MEDICINE AND PUBLIC HEALTH IS ESSENTIAL TO RELIABLE SURVEILLANCE.

*Sindy M. Paul, MD, MPH; Victor S.B. Jorden, MD, MPH; Carmine Grasso, MPH, MSW; and Samuel J. Costa, MA*

In the busy daily practice of medicine, submitting required disease reports to the health department is rarely a high priority. It may seem as though these reports disappear into a bureaucratic black hole that has no impact on medical practice. This is certainly not true for HIV disease reporting in New Jersey. The HIV and AIDS cases reported to the New Jersey Department of Health and Senior Services (DHSS) provide the foundation for decisions relating to resource allocation, including funding for counseling and testing, medical care, and access to the AIDS Drug Distribution Program formulary; planning and evaluation of prevention services; evaluation of the implementation of the US Public Health Service (PHS) for the prevention of perinatal HIV transmission and for the prevention of opportunistic infections; presence and transmission of variant strains of HIV; and changing trends in the epidemic.

Public health surveillance does not simply collect pertinent infor-

mation; the data is classified, interpreted, and, most important, used to define methods of intervention for a given health problem. The process then continues into the evaluation phase: new information is collected and analyzed to quantify the success of the intervention on managing the problem. DHSS surveillance in New Jersey has been used successfully in many fields, but one of the most important has been in the assessment and management of the HIV epidemic. AIDS has been a reportable disease by regulation in New Jersey since 1986. New Jersey was the first high-prevalence state to implement HIV reporting in October 1991. Through September 30, 1999, a total of 38,994 AIDS cases were reported and 14,751 persons with HIV disease (not AIDS) were reported.<sup>1</sup> New Jersey has the fifth highest prevalence of AIDS cases in the United States, ranks third in pediatric AIDS cases, and has the highest proportion of women among the cumulative AIDS cases in the country.<sup>2</sup>

Surveillance data is used to determine federal funding levels for cities and states under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990. The Health Resources and Services Administration distributes CARE Act dollars to states and cities for the development of comprehensive care systems for low-income individuals and families lacking other sources of payment for these services. The formula portion of the CARE Act awards is based on a 10-year weighted average of AIDS cases reported to the Centers for Disease Control and Prevention (CDC), which serves as an estimate of the number of individuals living with HIV and AIDS in each state and local jurisdiction.

During federal fiscal year 1999, approximately \$70 million from the Ryan White program was allocated to New Jersey under different titles of the CARE Act. Comprehensive surveillance activities play an important role in ensuring that New Jersey residents receive their fair share of federal resources to address this burgeoning epidemic.



In addition to federal funding, HIV surveillance data is also used in the annual appropriations process by the DHSS and the legislature. Therefore, reporting all cases of HIV and AIDS to DHSS is imperative for sufficient federal and state funding.

The number and distribution of counseling and testing sites, which provide free HIV counseling and assessment of serostatus, are also established at least in part on the number of reported HIV and AIDS cases. Physicians can refer patients to these sites; however, the results can only be sent to the physician with written permission from the patient. As with all HIV-infected persons, confidentiality must be strictly maintained according to NJAC 26:5C. Information on publicly funded counseling and testing sites can be obtained from the DHSS by calling (609) 984-6125 or on the DHSS Web site at [www.state.nj.us/health](http://www.state.nj.us/health).

Surveillance activities based on reported HIV/AIDS cases include evaluation of both the implementation and effectiveness of PHS recommendations. From the clinician's perspective of treating individual patients as well as the population-based health perspective of the DHSS, it is important to verify the effectiveness of PHS recommendations. New Jersey was one of the original venues in which a critically important set of recommendations of the PHS was validated: prevention of perinatal HIV transmission. The Pediatric AIDS Clinical Trials Group Protocol 076 (PACTG 076) proved that zidovudine (AZT, ZDV) use during pregnancy, labor and

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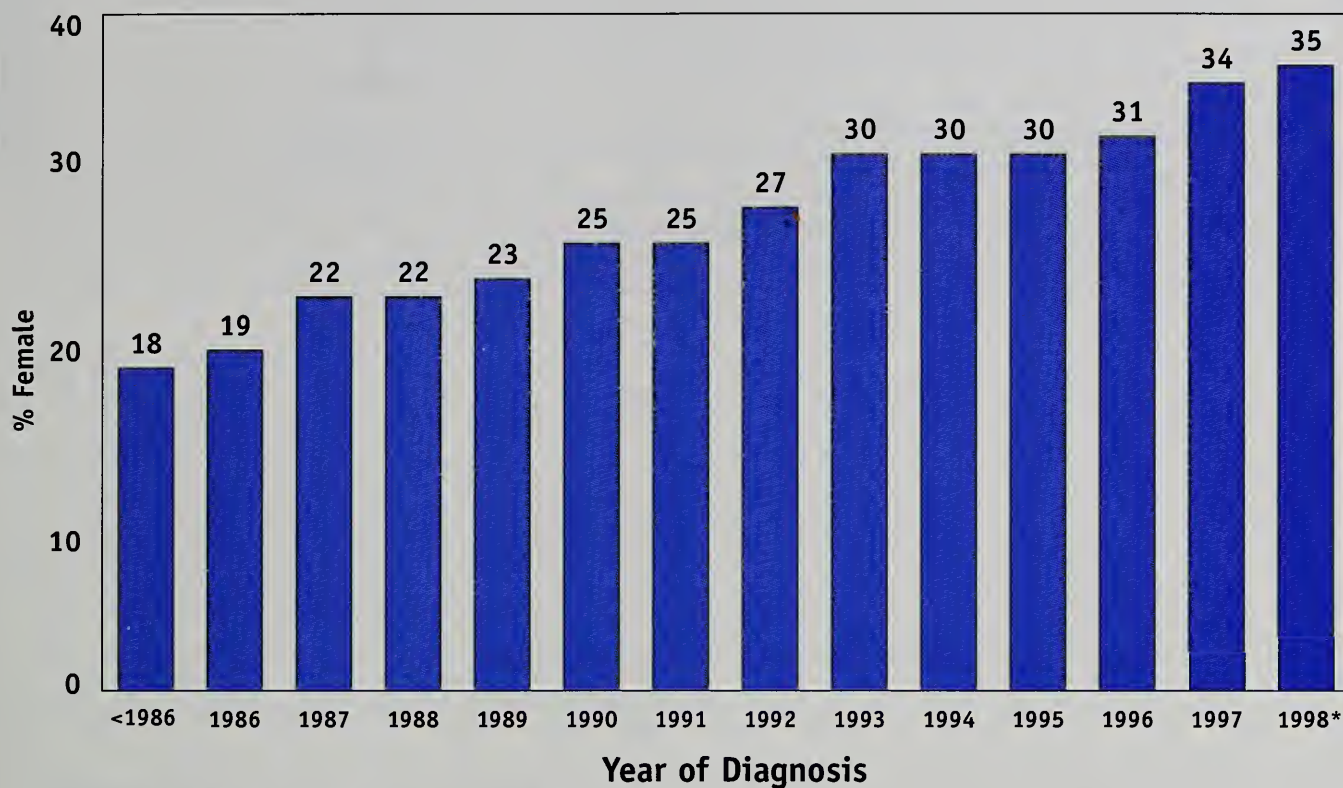
delivery, and in the neonatal period can reduce perinatal HIV transmission from 25% to 8%.<sup>3</sup> In August 1994, the PHS published recommendations for the use of AZT to prevent perinatal HIV transmission.<sup>4</sup> For children born in 1993, 26 (8%) of HIV-exposed children received perinatal AZT. As a result of the PHS guidelines, this proportion increased markedly, to 184 (71%), in birth year 1997. During these years, perinatal HIV transmission decreased from 69 (22%) in 1993 to 24 (12%) in 1997. Although there is continued room for improvement, statewide surveillance activities show that the PHS recommendations have been widely implemented and are indeed preventing perinatal transmission. Similar surveillance activities are currently being conducted in New Jersey to evaluate the implementation and effectiveness of PHS recommendations to prevent active tuberculosis in coinfecting persons and to prevent

*Mycobacterium avium* complex in HIV-infected children.

HIV reporting allows the DHSS to detect changing trends in the epidemic a decade or more sooner than with AIDS-only surveillance. Recognition of these changes is important for daily interactions with patients, prevention planning, and resource allocation. Three trends that have emerged recently are gender redistribution among 13 through 25 year olds, increasing reported cases among women, and a decrease in mortality among persons with AIDS. In the 13-to-25-year-old age range, males account for 61% of the cumulative reported AIDS cases. Females, however, account for the majority of those with HIV, constituting 51% of reported HIV cases in this age group. This changing trend emphasizes the need for physicians to discuss HIV disease with adolescents and young adults, perform a complete sexual and drug use history, and offer (or provide a referral for) counseling and testing. Since the women are of reproductive age, it also emphasizes the need to comply with NJAC 8:61-3.1, which requires providers to give HIV counseling and offer HIV testing to pregnant patients. Recommendations for the prevention of perinatal HIV transmission should be followed for HIV-infected pregnant women.

Overall, as seen in Figure 1, an increasing trend in HIV disease has been noted for women of all ages. Women initially accounted for less than 20% of the reported AIDS cases. Currently, women account for 35% of the reported AIDS cases.

Preliminary data in New Jersey indicates that the 36% mortality rate



\*1998 Diagnosis information incomplete  
Data as of 3/31/99

Figure 1. New Jersey Reported AIDS Cases: Female Percentage by Year of Diagnosis

for AIDS patients diagnosed in 1995 has decreased to 25% for AIDS patients diagnosed in 1998. This decline may reflect the advent of combination therapy and improved prophylaxis for opportunistic infections. Patients on combination therapy who live longer with HIV disease will need medical care for such complications as hyperglycemia and diabetes mellitus, lipid abnormalities, fat redistribution, and lactic acidosis with hepatomegaly and hepatic steatosis.<sup>5,6</sup> The emerging history of HIV-infected persons on combination therapy has yet to be fully described, but continued reliable surveillance efforts will certainly help to more precisely delineate important trends. It is hoped that questions concerning the

impact of lipid abnormalities on cardiovascular disease, the role of lipid-lowering agents, the management of diabetes-associated complications, and the role of surgery in the buffalo hump and protease pouches will be answered soon, but this will happen only through a collaboration of medicine and public health.

Special epidemiologic studies are conducted by the DHSS surveillance program. Investigations of unusual cases are conducted—for example, situations in which there is discordance between clinical presentation and laboratory findings. Recent special epidemiologic studies have identified the presence of variant strains of HIV in New Jersey and a case of HIV-1 group M subtype B

(the most common strain of HIV in New Jersey and in the United States) that was not detectable using currently FDA-approved HIV diagnostic tests.<sup>7</sup> Identification of variant strains of HIV can provide the foundation for further epidemiologic studies describing the predilection for transmission, immunologic response, and treatment response for these emerging pathogens within the HIV epidemic. These special studies can provide information, and possibly laboratory specimens, for the development of diagnostic tests and viral load monitoring tests that consistently and reliably detect these strains. Detecting and monitoring these strains are crucial for diagnosis, medical management, and protection of the blood supply.



In addition to HIV disease surveillance, the DHSS can collaborate with physicians to follow up on HIV-infected persons. The Notification Assistance Program (NAP) is a statewide service of the DHSS designed to provide follow-up services to health care providers for HIV-positive patients who do not return for test results, counseling, and medical referrals. The NAP can also contact the sexual or needle-sharing partners of patients to provide confidential counseling and testing. The NAP is a voluntary, confidential service through which no partners will become aware of the source of the referral or the identity of the HIV-positive individual naming them. Health care providers interested in using NAP services for locating contacts or providing follow-up for their HIV-positive patients can call the NAP at (877) 356-8312. The NAP is not part of surveillance. The HIV surveillance system cannot and will not be used for partner notification.

Collaboration between medicine and public health is essential to control any major health problem in our community, and this cooperation has never been so important as in managing the AIDS epidemic. Clinicians provide a vital link with counseling and testing services to maximize the number of persons who know their serostatus, in addition to providing information on prevention and medical management for those who are infected. Case reports for HIV and AIDS allow public health to optimize resource allocation, detect emerging trends, provide prevention services, and evaluate the effectiveness of PHS

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recommendations. The critical importance of federal and state funding commensurate with the size of New Jersey's HIV/AIDS population is an additional reason why surveillance must be conscientiously addressed by all members of the health care community. Providers and laboratories are required (NJAC 8:57-2.1-2.7) to report all cases of HIV, AIDS, CD4 counts of less than 200 or 14%, and viral load results to the DHSS. Information on reporting requirements and report forms can be obtained by calling (609) 984-5940 or (973) 648-7500. Surveillance data is available on the department's Web site at [www.state.nj.us/health](http://www.state.nj.us/health). ■

*Sindy M. Paul is medical director, Division of AIDS Prevention and Control; Victor S.B. Jorden is resident in preventive medicine; Carmine Grasso is acting director, care and treatment, Division of AIDS Prevention and Control; and Samuel J. Costa is director, surveillance, Division of AIDS Prevention and*

*Control, all at the New Jersey Department of Health and Senior Services.*

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# Medical Society of New Jersey

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# TREATMENT OF CHRONIC PAIN SYNDROME

WE ADDRESS THE PSYCHOLOGICAL AND PHARMACOLOGICAL TREATMENT OF CHRONIC PAIN SYNDROME. THE COMMONLY USED PAIN MANAGEMENT PROTOCOLS IN EACH AREA ARE DESCRIBED. PSYCHOLOGICAL MANAGEMENT PROCEDURES THAT ARE COVERED INCLUDE RELAXATION METHODS, PATIENT EDUCATION, COGNITIVE THERAPY TECHNIQUES, AND PATIENT COMPLIANCE ENHANCEMENT. CONCERNING PHARMACOLOGICAL MANAGEMENT, THE WORLD HEALTH ORGANIZATION LADDER ANALGESIC GUIDELINES ARE DESCRIBED, AS WELL AS ADJUNCT MEDICATIONS, SUCH AS ANTIDEPRESSANTS, ANXIOLYTICS, AND HYPNOTICS.

*Steven E. Weitz, PhD, Philip H. Witt, PhD, and Daniel P. Greenfield, MD, MPH*

Chronic pain is a debilitating and demoralizing condition. Unable to obtain relief, patients frequently become clinically depressed and anxious. Family members suffer as well, since the impact of chronic pain syndrome affects all who are close to the patient. A vicious cycle ensues between chronic physical pain and psychological dysfunction, where each condition exacerbates the other. Comprehensive treatment of chronic pain syndrome requires that both its psychological and pharmacological management needs be addressed. In this article, we review the typical psychological and psychiatric treatments for chronic pain.

## Psychological Management

Certain key elements are present in virtually all chronic pain manage-

ment treatment protocols. Relaxation training in its many variants—including meditation, mindfulness training, and biofeedback training—is a core element in treating chronic pain.<sup>1</sup> It has long been accepted that there is a relationship between pain and anxiety in that anxiety both increases the experienced intensity of pain and causes chronic physical tension, itself a pain generator. Consequently, relaxation training is among the most commonly prescribed psychological treatment methods for chronic pain syndrome. Relaxation training is relatively easy to implement. The physician, psychologist, or trained nursing staff can provide a guided relaxation induction in the office. The induction can be tailored to the patient's particular needs, perhaps

focusing on a physical area in which the patient experiences tension or pain. The relaxation induction can be audiotaped, and the patient can practice by listening to the tape at home. Research indicates that conscientious home practice can result in lowered levels of both experienced anxiety and experienced pain.

One frequent complicating factor in chronic pain cases is sleep disturbance. Insomnia and nonrestorative sleep wear patients down, both physically and psychologically. As such, chronic pain patients often benefit from instruction in proper behavioral sleep hygiene.<sup>2,3</sup> Patients should be counseled to regulate their sleep cycle by keeping the same bedtime and waking time each day. To strengthen the association between sleep behavior and the bed,



activity in bed should be restricted to sleeping and sex. For the same reason, if patients lie in bed awake for more than 20 minutes, they should leave the bed, returning only when they feel sleepy.

Evening alcohol consumption as well as eating meals or large snacks near bedtime should be avoided. Caffeine consumption should be reduced or eliminated. Patients should refrain from daytime naps unless unavoidable, in which case they should not nap after 2 PM. And while midday physical exercise can facilitate sleep, patients should not exercise within two hours of bedtime.

Educating patients and their families about the nature of chronic pain is a core component of treatment. First, the health care professional must help patients appreciate the distinction between acute and chronic pain.<sup>4</sup> Acute pain refers to a physiological response to a noxious stimulus, associated typically with actual tissue damage, over which the patient has little or no control.<sup>5</sup> In contrast, chronic pain, following Bonica, persists beyond the usual course of a given acute disease or is associated with a chronic pathological process.<sup>6</sup> Chronic pain, unlike acute pain, has a clear psychological component that is subject to patient control by application of cognitive and behavioral pain management techniques. In addition, family members require guidance in their efforts to support the chronic pain

patient. On the one hand, their sympathy and emotional nurturance can diminish the patient's sense of isolation and depression. On the other hand, too much accommodation to pain-related disability behavior can unintentionally undermine the patient's efforts to be as independent and self-sufficient as possible. Both the patient and the family should be taught to view chronic pain as a problem exacerbated by passivity and the expectation that doctors are the only source of relief through medication or surgery. They must understand that the patient can acquire a meaningful measure of control over pain by becoming the doctor's active partner in pain management.

During the past 20 years, cognitive-behavioral therapy has found the strongest empirical support for managing aversive experiences, ranging from depression to anxiety to chronic pain. A key tenet of cognitive-behavioral therapy is that one's thoughts (i.e., cognitions) have a strong controlling influence on emotions, behavior,

and experience. By identifying and altering maladaptive thoughts, people can change the nature of their experience.<sup>7</sup>

Chronic pain patients are prone to thinking about their conditions in catastrophic terms (e.g., "I can't stand this any longer" or "There's nothing I can do about my condition—I must have surgery"). Such thinking leads to helplessness and despair. Patients benefit by learning to manage their catastrophic thoughts effectively. They can be coached both to develop more realistic expectations and to rationally dispute their catastrophic cognitions. Developing realistic expectations is critical. Many chronic pain patients have debilitating physical conditions that prevent them—even under the best of circumstances—from achieving a level of mobility they once enjoyed. For treatment to succeed, patients need to grieve their loss of bodily integrity and be helped to accept their condition without capitulating to it.

Chronic pain patients frequently restrict their physical activity in the belief that activity will inevitably exacerbate their pain. An insidious process ensues: chronic pain leads to anxiety about engaging in physical activity, which ultimately results in physical deconditioning, a problem that itself complicates the chronic pain syndrome.<sup>8</sup> The treating health care professional must interrupt this cycle by encouraging the chronic

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pain patient, under proper supervision, gradually to increase physical activity.

The health care professional should pay specific attention to enhancing the patient's treatment protocol compliance. An extensive literature regarding treatment protocol compliance has developed over the past decade. Some major principles include the following.<sup>9,10</sup>

*Using trained paraprofessional staff to provide educational modules for patients.* Chronic pain patients can readily be taught the difference between acute and chronic pain, the general principles of relaxation training and pain management, and similar matters by a trained and supervised paraprofessional or even, in part, through video. The supervising physician or psychologist can consult on difficult cases or to resolve impasses in treatment.

*Providing a menu of choices for the patient.* Patients cooperate better with treatment protocols when they play a role in choosing their protocol. Discussing options from which the patient can choose increases the patient's sense of ownership and commitment to the treatment plan.

*Understanding the patient's thinking about the disorder.* Patients frequently have unarticulated, unexpressed theories of their disorders. Without understanding the patient's private explanation for the chronic pain syndrome, the health care professional and patient may end up working at cross-purposes.

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During the initial phase of treatment, the psychologist should carefully assess any preexisting psychological or interpersonal problems that contribute to or are aggravated by the chronic pain syndrome. For example, a family history is often useful for assessing how both the marital family and the family of origin have dealt with similar illnesses in the past. Certain preexisting psychological problems—such as depression or anxiety disorders—can be aggravated by the experience of chronic pain, and a careful history regarding these matters should be taken. Finally, the presence of a personal injury lawsuit or disability claim can be a complicating factor in treatment, slowing recovery by presenting incentives to remain ill.

Certain psychological disorders, especially anxiety and depression, are so frequently comorbid with a chronic pain syndrome that a careful assessment will always evaluate for

their presence. It is not at all unusual to find a chronic pain patient presenting with a clinically significant depression, since a loss of functioning associated with chronic pain can so easily precipitate a depression. Dysphoria, anhedonia, hopelessness, cognitive difficulties, loss of libido, crying spells, and suicidal ideation are depressive symptoms that frequently accompany a chronic pain syndrome. Consequently, the instigation of reasonable hope, the cultivation of self-efficacy, and the adoption of an action plan are essential with chronic pain patients. Cognitive-behavior therapy and interpersonal therapy are the two empirically supported treatments of choice for such difficulties.

### **Pharmacological Management**

Long recognized as the mainstay treatment modality of physicians in managing chronic pain, pharmacotherapy remains an important element in an interdisciplinary approach to effective treatment. Medications for chronic pain may be divided into two types: analgesic agents to treat the pain itself, and psychotropic agents (such as antidepressants and antianxiety agents) to treat concomitant psychiatric/psychological conditions.<sup>11</sup>

Analgesic medications for treating chronic pain on a maintenance basis may be effectively prescribed at one of three levels, according to the "Three-Step Analgesic Ladder" model of the World Health Organization (WHO).<sup>12</sup> The WHO



ladder begins with relatively low doses of low-potency analgesic medications and progresses systematically and incrementally to higher doses of more potent medications (specifically, opioids) as pain worsens. The three steps involve use of:

- Nonopioid analgesic medications with or without coanalgesic agents (such as NSAIDs) in Step 1.
- Lower-potency opioids with or without nonopioid coanalgesic agents as pain persists or increases from mild to moderate levels in Step 2.
- High-potency opioids with or without nonopioid coanalgesic agents as pain persists or increases to moderate to severe levels in Step 3.<sup>13</sup>

In all of these steps, the treating clinician must realize and accept that chronic pain by definition does not go away.<sup>14,15</sup> Whatever WHO step is involved, prescribing should be on an ongoing, maintenance basis at a sufficiently high dose level to treat the patient's chronic pain effectively. While use of opioids remains controversial, we recommend that physicians follow the WHO ladder guidelines, prescribing adequate medication at each step.

Adjunct psychotropic medications are also effective in managing chronic pain syndromes. Two classes of these medications for the treatment of two prevalent associated sets of symptoms deserve mention. Antidepressants, such as tricyclics (e.g., Elavil [amitriptyline], Tof-

ranil [imipramine]) and selective serotonin reuptake inhibitors (e.g., Prozac [fluoxetine], Zoloft [sertraline], Paxil [paroxetine], and Effexor [venlafaxine])<sup>16</sup> may be useful for the pharmacological treatment of depression in patients with chronic pain syndromes. Antidepressants are especially indicated with those patients with vegetative, or biological, symptoms of depression, including sleep disturbances (early morning awakening, delayed sleep onset, broken sleep, and other variants), anorexia, reduced energy level, anhedonia, and diminished libido. Anxiolytics, similarly, may be useful both in treating daytime anxiety and primary nighttime insomnia (i.e., insomnia not secondary to depression). The benzodiazepines (on a time-limited basis)<sup>17</sup> and

BuSpar (buspirone) are the most widely prescribed of these agents and may be prescribed during the day (for daytime anxiety) or at night (as a hypnotic agent). The particular anxiolytic can be selected for such desired pharmacological and pharmacokinetic properties as rapidity of onset, duration of action, or accumulation (or nonaccumulation) of active metabolites.<sup>18</sup> Two nonbenzodiazepine hypnotics, Ambien (zolpidem) and Sonata (zaleplon), are particularly useful to assist sleep, given their rapid onset and short half-lives, with the result that patients suffer little or no grogginess on awakening.

## Conclusion

Since chronic pain syndrome can be a refractory disorder to treat, a multidisciplinary approach, including pharmacological and psychological interventions, is frequently required. Pharmacological treatment has been used for decades with chronic pain treatment, and at present detailed guidelines are available for its use, although controversy still exists regarding opioid use. Psychological approaches have gained increasing empirical support in recent years, particularly those approaches including relaxation training, cognitive therapy, and treatment compliance enhancement. Physicians would be well-advised to consider both treatment modalities in treating chronic pain syndrome to ensure their patients

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receive the highest level of care possible.

Steven E. Weitz is a principal in Associates in Psychological Services, P.A. in Somerville NJ and consulting psychologist at The New Jersey Spine Institute in Bedminster NJ. Philip H. Witt is a principal in Associates in Psychological Services, P.A. in Somerville NJ; clinical assistant professor in the department of psychiatry at Robert Wood Johnson Medical School—UMDNJ in Piscataway NJ; and a visiting lecturer at the Graduate School of Applied and Professional Psychology at Rutgers in Piscataway NJ. Daniel P. Greenfield is in independent practice in Millburn NJ; on the clinical faculty of Albert Einstein College of Medicine/Montefiore Medical Center in the Bronx; and on the clinical faculty of Seton Hall University School of Graduate Medical Education/New Jersey Neuroscience Institute in South Orange NJ.

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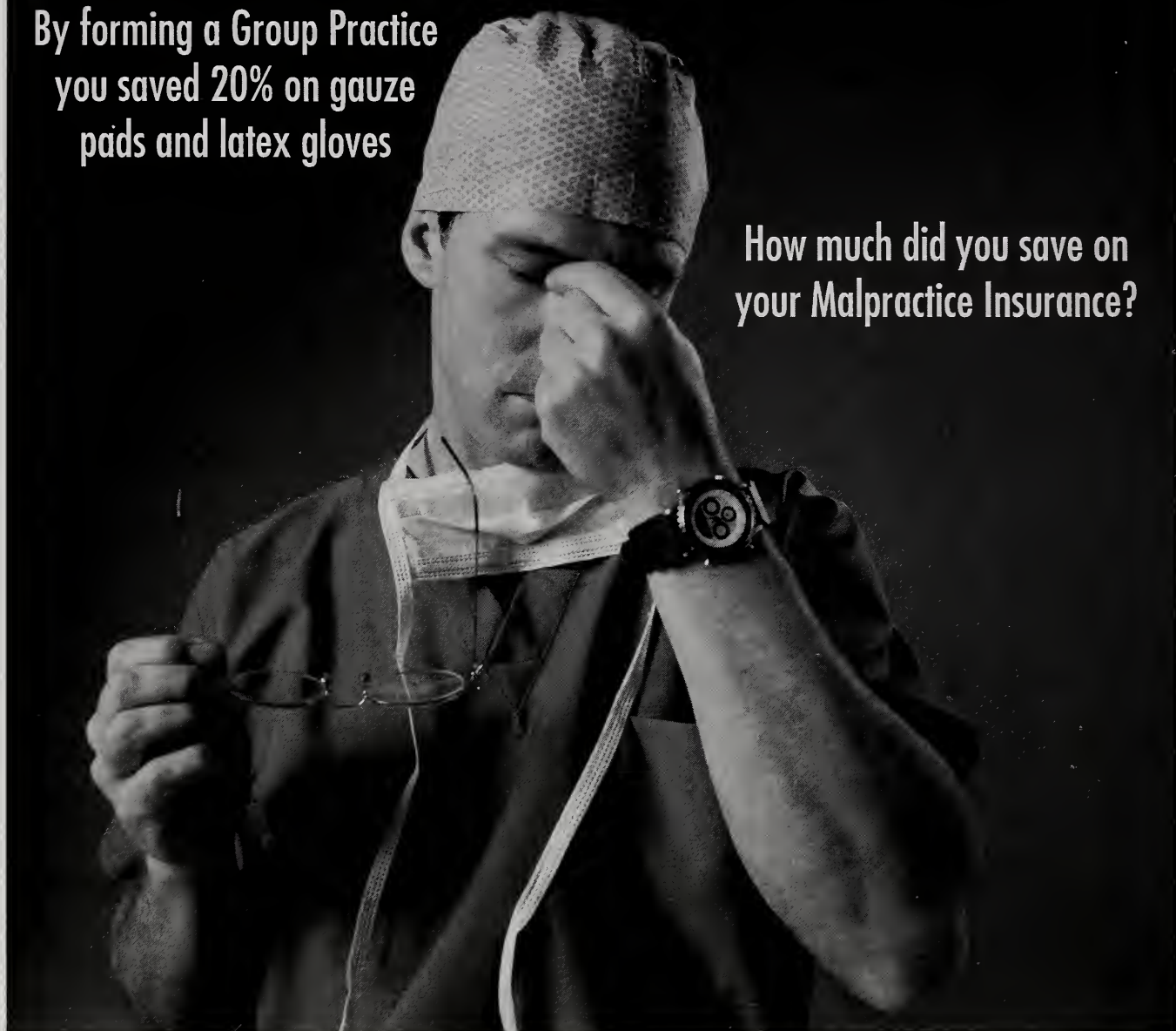
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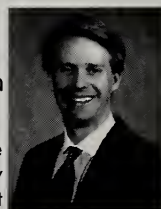


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Tune in on April 4 at 9 PM and participate in a unique interactive television program entitled *A Community Conversation on Public Health*. Sponsored by the NJ Department of Health and Senior Services (DHSS), the show will air live from New Jersey Network's (NJN's) Trenton studio before an audience of about 300 leaders in public health and community organizations.

The goal of the 60-minute show is to discuss what public health really means to the people of New Jersey and to engage in a conversation about the readiness of the public health community to tackle the challenges in this new century. The show is timed to coincide with National Public Health Week.

Some of the topics for the hour will be "What is Public Health?" "The Tobacco Menace," "Seniors and Healthy Lifestyles," and "Healthy NJ 2010, What Is It and Why Should I Care?"

The three-member panel, which will serve as the catalyst for discussion and commentary, includes DHSS Commissioner Christine Grant; Dr. Robert Johnson, professor of pediatrics and clinical psychology at UMDNJ-NJ Medical School; and Dr. J. Michael McGinnis, senior vice president and director of the health group at the Robert Wood Johnson Foundation.

The show is being funded and developed by the DHSS and will be hosted by NJN health reporter Sara Lee Kessler. The interactive hour will include telephone calls, e-mails, Web site communication, and faxes from the public as well as spirited discussions with members of the audience.

**PROSTATE CANCER RESEARCH STUDY OPENS**

Robert DiPaola, MD, the clinical director of the Dean and Betty Gallo Prostate Cancer Center at the Cancer Institute of New Jersey (CINJ), announced that the CINJ has begun enrolling patients in a new clinical trial using a genetically engineered vaccine to fight advanced

prostate cancer. Dr. DiPaola is the coauthor of the study and serves as coprincipal investigator. The Eastern Cooperative Cancer Group sponsors the trial. For eligibility requirements, call (732) 235-7577. For general information, call (732) 235-CINJ.

**VIRTUA HEALTH AND REHABILITATION CENTER AT BERLIN**

Virtua Health and Rehabilitation Center at Berlin hosted a grand opening on January 22. The center, located adjacent to Virtua-West Jersey Hospital Berlin at 100 Townsend Road, offers a wide range of services, including access to

emergency medical care, 24-hour nursing care, physical and occupational therapy, social service, activities, homestyle dining, and more. For more information, call (856) 322-3600.

**STATEWIDE COALITION AIMS TO IMPROVE OPTIONS IN END-OF-LIFE CARE**

The New Jersey Comfort Care Coalition, an association of health care organizations, public and private agencies, and educational institutions, is working to create more comfortable, compassionate end-of-life care. The group plans to use grant funds and donations to improve end-of-life care practices

and policy. The Coalition's lead group is New Jersey Health Decisions, a nonprofit organization that aims to improve public dialogue on medical ethics issues and encourage informed decision-making by individuals. For more information, call (973) 857-5552; e-mail [HealthDec@aol.com](mailto:HealthDec@aol.com).

**NEW LAW PROTECTING HEALTH CARE WORKERS FROM NEEDLESTICK INJURIES**

Legislation sponsored by Assembly members Alan Augustine and Barbara Wright that will help reduce needlestick injuries was signed into law by Governor Christine Whitman. Under the new law, hospitals and health care facilities have one year to replace existing needles with safer alternatives selected by the commissioner of the state Department of Health and Senior Services. New Jersey's health care facilities will also be required to provide the education and training necessary for using the new needles, develop a mechanism to continually review and evaluate new equipment on the market, and report all needlestick injuries to the Department of Health and Senior Services quarterly.



**PHYSICIAN EXECUTIVES OF PROVIDER ORGANIZATIONS BEWARE**

On January 3, the United States Supreme Court decided to hear argument on a lower court's ground-breaking decision permitting a patient to sue physicians who are executives in physician-owned and -operated HMOs on grounds that they may have breached their fiduciary duties under the Employee Retirement Income and Security Act (ERISA) to HMO participants. The Supreme Court's decision will have significant and far-reaching effects.

ERISA is a statutory scheme that regulates all private employee benefit plans, including both pension and welfare plans. The definition of "welfare plan" includes a plan maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries. ERISA establishes uniform standards, including rules relating to fiduciary responsibilities under such plans.

The plan at issue in the case before the Supreme Court is a physician-owned and -operated prepaid health insurance plan. The patient had gone to a plan physician who found an inflamed mass in her abdomen. The situation was designated nonemergent, which under the plan required the patient to wait and be treated at the HMO's facility by the HMO's physicians. During the eight-day waiting period, the patient's appendix ruptured and she suffered peritonitis.

The patient sued, alleging not only medical malpractice but also

breach of fiduciary duty under ERISA. ERISA has in the past been a bar to claims against an HMO, while permitting traditional state court claims of malpractice to go forward. The lower court, however, found that because:

- the physician-providers managed the plan, including the doctor referral process, the nature and duration of patient treatment and the extent to which participants were required to use HMO-owned facilities,
- the owner-physicians had the exclusive right to decide all disputed and nonroutine claims, and
- the board of directors of the HMO consisted exclusively of the plan physicians who were thus in control of each and every aspect of the HMO's governance, "including their own year-end bonuses,"

a potential conflict existed between the interests of the plan participants and the physician owner-operators that would, if proved, constitute a breach of the physicians' fiduciary duty under ERISA. The claim of breach of fiduciary duty was reinstated and permitted to go to trial.

The United States Supreme Court will hear argument on the appeal of this decision before June. Its decision will likely change the landscape across the board with regard to the potential liability of operators of all health benefit plans.

**OVERLOOK HOSPITAL RECEIVES GOVERNOR'S AWARD**

Overlook Hospital received the New Jersey Governor's Award for Performance Excellence—the highest state honor an organization can receive for quality performance. The New Jersey Governor's Award is based on the criteria for the Malcolm Baldrige National Quality Award, established by Congress in 1987 to enhance the competitiveness of US businesses by promoting quality awareness.

**FIRST-TRIMESTER DOWN'S SYNDROME SCREENING**

As part of a federally funded national study, first-trimester Down's syndrome screening is now available at Capital Health System in Trenton. Through its association with Thomas Jefferson University Hospital, where researchers are leading the study, the CHS maternal fetal medicine department sees about four to five patients per week. There is no charge for the screening, and referrals from insurance companies are not necessary. Most pregnant women between 10 1/2 and 13 1/2 weeks are candidates for the screening test. The new method appears to detect about 90% of fetuses with Down's syndrome or trisomy 18. For more information, call Carolee J. Watkins, MS, MA, (609) 394-4072, ext. 2.

## In Memoriam

**Baldwin, Jr, Clifford A., MD** November 21, 1922–July 12, 1999. Jefferson Medical College (1946), Ocean County, Anesthesiology

**Cooper, Ray C., MD** July 14, 1918–July 6, 1999. Jefferson Medical College (1944), Warren County, General

**De Fusco, G. Thomas, MD** June 9, 1907–November 3, 1999. Georgetown University (1931), Hudson County, Internal Medicine

**Feinsmith, Burton M., MD** December 14, 1926–December 29, 1999. University of Bern, Switzerland, (1961), Union County, Pediatrics

**Feldman, Arnold, MD** February 6, 1924–September 1, 1999. University of Pittsburgh (1949), Essex County, Pediatrics

**Jehl, Joseph R., MD** August 15, 1907–December 18, 1999. New York University (1932), Passaic County, Pediatrics, Allergy

**Judge, Thomas V., MD** August 13, 1916–July 14, 1999. Columbia University (1941), Essex County, Obstetrics and Gynecology

**Kaye, J. Walter, MD** December 19, 1932–April 19, 1999. Wayne State University School of Medicine (1957), Essex County, Dermatology

**Klein, Andrew J., MD** December 10, 1906–July 18, 1999. Edinburgh University (1934), Essex County, Internal Medicine

**Lippmann, Heinz I., MD** May 21, 1908–May 4, 1998. University of Munich Medical School (1931), Bergen County, Peripheral Vascular Diseases

**Nadel, Charles I., MD** July 28, 1906–January 3, 2000. University of Pennsylvania (1928), Essex County, Orthopaedic Surgery

**Pedicini, Salvador A., MD** June 30, 1917–August 26, 1999. Bologna University (1957), Essex County, General

**Ressetar, Michael J., MD** November 8, 1914–December 26, 1999. Jefferson Medical School (1942), Passaic County, General

**Sinha, Sailendra K., MD** July 7, 1925–November 23, 1998. University of Calcutta (1951), Ocean County, Pathology

**Small, Richard H., MD** November 24, 1926–July 29, 1999. Jefferson Medical College (1951), Monmouth County, Obstetrics and Gynecology

### PAST PRESIDENT OF THE MEDICAL SOCIETY OF NEW JERSEY

Joseph Jehl, MD, died December 18, 1999, at the age of 92. He was a long-standing member of the Passaic County Medical Society and a past president. He was president of MSNJ in 1966-67. He practiced pediatrics and was a physician in the department of pediatrics of St. Joseph's Hospital in Paterson. Nicholas Bertha, also a past president of MSNJ, recalled with fondness their association as medical students at New York University and as interns at Bellevue Hospital in New York City. Dr. Jehl took further training

in pediatrics in Passaic General Hospital.

In addition to being a skilled and caring physician, Dr. Jehl was an excellent botanist and horticulturist. He shared his knowledge of flowers with many; I learned first-hand of his skill in teaching from his instruction on the propagation of geraniums, begonias, and dahlias. His lessons were sprinkled with his wry sense of humor and love.

**Carl Restivo, Jr, MD**

MSNJ President 1997-98

### AN ATLANTIC CITY ICON

Joseph McGahn, MD, died on December 24, 1999, at the age of 82. An obstetrician, he defeated state Senator Frank "Hap" Farley, one of the strongest political figures in South Jersey, in 1981 and served as Democratic state senator from 1972 to 1978. While there, he worked in support of introducing gambling in Atlantic City through the adoption of the Casino Control Act. Before becoming a state senator, he was mayor of Absecon.

He was born in Atlantic City, graduated from St. Mary's College in Maryland, and received his medical degree from the University of Pittsburgh. At the onset of his career in

obstetrics and gynecology, he was associated with the late Dr. Joseph Stella; for many years they were the premier practice in Atlantic City. Later in his career he became an emergency room physician and helped coordinate the care for the casino workers and patrons.

He was a member of the Medical Society of New Jersey and the Atlantic County Medical Society from 1947 to 1980.

His contributions to the medical community as well as his political accomplishments will not be forgotten. He will be missed by his friends, patients, and colleagues alike.

**Joseph A. Varallo, MD, FACOG**



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## E V E N T

## D A T E

## L O C A T I O N

## M a r c h

|                                              |                   |                                                                               |
|----------------------------------------------|-------------------|-------------------------------------------------------------------------------|
| <b>Contraceptive Technology</b>              | March 15-18, 2000 | Grand Hyatt, Washington DC, Contemporary Forums, (925) 828-7100               |
| <b>Clinical Infectious Disease 2000</b>      | March 17-19, 2000 | New York City, Center for Bio-Medical Communication, (201) 342-5300           |
| <b>Nephrology Society Meeting</b>            | March 21, 2000    | UMDNJ-Robert Wood Johnson Medical School, New Brunswick, AMNJ, (609) 275-1911 |
| <b>Post-Polio Syndrome</b>                   | March 22, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>NJ State Society of Anesthesiologists</b> | March 24, 2000    | Trump Plaza Hotel & Casino, Atlantic City, (609) 275-1911                     |
| <b>Travel-Related Illness</b>                | March 29, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Vascular Society of New Jersey</b>        | March 29, 2000    | Morristown Memorial Hospital, AMNJ, (609) 275-1911                            |

## A p r i l

|                                                                                               |                   |                                                                                               |
|-----------------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------------------------|
| <b>Diagnosis and Management of Urinary Problems and Other Pelvic Floor Disorders in Women</b> | April 1, 2000     | Garden City Hotel, Garden City NY, Center for Bio-Medical Communication, Inc., (201) 342-5300 |
| <b>Medical Problems in the Elderly</b>                                                        | April 5, 2000     | St. Mary's Hospital, Passaic, (609) 275-1911                                                  |
| <b>NJ Orthopaedic Society Annual Meeting</b>                                                  | April 8, 2000     | Caesar Park Penha, Subtra, Portugal, AMNJ, (609) 275-1911                                     |
| <b>Hepatitis</b>                                                                              | April 12, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                                            |
| <b>American Surgical Association</b>                                                          | April 13-15, 2000 | Philadelphia Marriott Hotel, (978) 526-8330                                                   |
| <b>Nephrology Society Meeting</b>                                                             | April 18, 2000    | UMDNJ-Robert Wood Johnson Medical School, New Brunswick, AMNJ, (609) 275-1911                 |
| <b>Peripheral Vascular Disease</b>                                                            | April 19, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                                            |
| <b>Polymyalgia Rheumatica</b>                                                                 | April 26, 2000    | St. Mary's Hospital, Passaic, (609) 275-1911                                                  |

## M a y

|                                                      |                 |                                                              |
|------------------------------------------------------|-----------------|--------------------------------------------------------------|
| <b>First Annual New Jersey Physicians Conference</b> | May 4-7, 2000   | Atlantic City Convention Center, MSNJ, (609) 896-1766        |
| <b>American Occupational Health Conference</b>       | May 12-19, 2000 | Pennsylvania Convention Center, Philadelphia, (847) 818-1800 |



## E V E N T

## D A T E

## L O C A T I O N

## M a y

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Research, Diagnosis, and Treatment**

May 14-17, 2000

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**Greater New York Physicians Expo**

May 16-17, 2000

Javits Convention Center, New York,  
(212) 216-2000

**Digestive Disease Week**

May 18-24, 2000

Washington DC, (609) 848-1000

**AMNJ Annual Awards Dinner**

May 24, 2000

Chanticleer, Short Hills, AMNJ, (609) 275-1911

## J u n e

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Applications in Radiology**

June 3-6, 2000

Philadelphia Marriott Hotel, (703) 757-0054

**Meningitis**

June 7, 2000

St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911

**Third International Conference on  
the Mechanisms and Treatment of  
Neuropathic Pain**

June 8-10, 2000

Renaissance Hotel, Washington DC,  
(514) 286-0855

**AMA Annual Meeting**

June 11-15, 2000

Chicago Hilton & Towers, (312) 464-5000

**Rheumatoid Arthritis: A New Look  
at an Old Disease**

June 14, 2000

St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911

**Nephrology Society Meeting**

June 20, 2000

UMDNJ-Robert Wood Johnson Medical School,  
New Brunswick, AMNJ, (609) 275-1911

**Tuberculosis 2000**

June 20-24, 2000

The Roosevelt Hotel, New York,  
(202) 737-3600

**Chronic Pain Management**

June 21, 2000

St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911

**Building Systems That Do No Harm:  
Advancing Patient Safety Through  
Partnership And Shared Knowledge**

June 28-30, 2000

Dallas TX, (312) 543-5658

## J u l y

**International Conference on Alzheimer's  
and Related Disorders**

July 9-14, 2000

Washington DC, (312) 335-8700

**13th International Symposium  
on Treatment of Leukemia,  
Lymphoma, and Cancer**

July 14-18, 2000

New York, Imedex USA, (770) 751-7332

**Update and Intensive Review  
in Internal Medicine**

July 30-Aug. 5, 2000

New York, (212) 781-5990

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The principal aim in the preparation of a contribution should be relevance to health care and to the education of patients and health care professionals. The contents of each issue include an important health care development; an in-depth interview highlighting a health care newsmaker; an update on a key public health issue; a peer-reviewed clinical report; brief highlights of the latest events and findings in the health care industry; and a monthly forum for readers. Proposals for special submissions will be considered on an individual basis. Letters to the editor are welcome and will be edited and published as space permits. Notices of events, programs, and meetings are encouraged.

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1766, fax (609) 896-1368, e-mail [kkelly@msnj.org](mailto:kkelly@msnj.org) or [cmagnolo@msnj.org](mailto:cmagnolo@msnj.org).

**SPECIFICATIONS.** Materials compatible with Microsoft Word 6.0 for Windows must be submitted on diskette (3 1/2 inch) or as an e-mail attachment, accompanied by a printed copy of the material, a cover letter identifying the submission, and a copyright form.

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# REFLECTIONS

## THE QUESTION

*Sanford M. Lewis, MD*

Physician parents of the generation now coming of age may have to counsel daughters and sons when a compelling question challenges their wisdom. "Should I study medicine?" they may ask us. And we struggle to answer out of a tumultuous past and uncertain professional future. Would we—again? Should they?

It was great, once the preclinical years were somehow endured, and the white coat had become a garment rather than a hopeful symbol. The deep emotional surge of the power to heal, the expansion of self through professional maturity, the pacification of anxiety with financial stability and a place in the community—all represented dimensions of fulfillment. We knew—often, at least—what to do and how to do it. Guided by an ethical framework and the imperatives of clinical need, we assumed that a prosperous and grateful society would bear the costs. That society, now spoken for by its financial institutions, is becoming history. Clinical success remains honored but just conditionally. The bottom line dictates reality.

And yet, realistically acknowledging contrary opinions, we might suspect that many among us would still answer affirmatively to our children. The fundamental ethos of medicine and its practitioners does not change. Financial and regulatory substrates, undergoing painful and rapidly evolving metamorphosis, show signs of veering toward a more rational equilibrium, and there are experienced

counselors to aid in avoiding pitfalls. Rehabilitation is just as possible for national systems as it is for patients. Doctors can be influenced by legislators, courts, and financial instruments, but they cannot be replaced. And there are other dividends. The title of doctor for an MD is much more than an honorary one. Many among us have been enthusiastically recruited into community affairs because of an almost subliminal conviction that assumed intelligence plus education plus compassion plus an intimate knowledge of the human condition make us desirable, if not always as leaders, often as respected elders. There is a subtle deference, shown in a restaurant, or on the road, or in the local stores, which seems to say "here is someone who has achieved," and the title is rarely omitted. As expectations for longer, healthier, and more fulfilling life spans grow, we are the messengers who carry the gifts from the laboratories into the lives of our neighbors. And this will be so whether the market surges or falters, whether liberals or conservatives hold evanescent power, or whether medical care is distributed by Plan A or B. The treatment and cure of disease is indifferent to such ephemera.

"Yes, my daughter—my son, if you really wish to, and if you can take the inevitable heat . . . I would be very proud to call you: physician!"



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## Quantifying Drug Treatment Quality

Amid the ongoing furor over reimbursement to hospitals, physicians, nursing homes, and home health agencies, payors and politicians are turning their attention to yet another cost item—prescription drugs. *Health Affairs* has dedicated its entire current issue to the pharmaceutical scene.

In the *Health Affairs* issue, Harvard School of Public Health professor Peter Neumann and colleagues review their own database of reported studies and conclude that drugs frequently do save money, because alternative treatments may be more expensive. The researchers point out, however, that drug therapies are reported to fare much better in studies funded by the pharmaceutical industry than in studies funded by less biased sources.

**Cost Utility Analysis.** To come up with these results, the researchers employ cost utility analysis. This relatively sophisticated form of cost-effectiveness analysis presents results in terms of cost per quality-adjusted life-year (QALY). The

advantage of QALY measures is that they take into account both survival and the value that people place on diverse outcomes of care.

Reviewing cost utility analyses published between 1975 and 1997, the Neumann team found an average prescription drug cost per QALY of \$11,000. Studies sponsored by drug companies show average costs of \$5,000, while studies sponsored by researchers without any ties to the health care industry show average costs of \$13,000. (Incidentally, the average immunization cost per QALY is only \$2,000, and the average cost per QALY of certain therapeutic medical procedures, such as blood transfusions, runs as high as \$140,000.)

As far as methodology goes, please take the Neumann article as an early warning. With increasing frequency, health policy analysts and health service researchers will subject physicians and other health care providers to accountings of costs and benefits. This may seem

unfair, but providers who are found to produce less quality of care at higher costs will be hard-pressed to defend their practices.

**Direct to Consumers.** Still with us? Another *Health Affairs* piece notes some of the problems with direct-to-consumer (DTC) advertising by pharmaceutical manufacturers. UCLA professor of medicine

**H**MOs provide more primary and preventive care and reduce financial barriers to care.

They also provide less specialty care, raise administrative barriers to care, and reduce patient satisfaction and trust in physicians. HMOs do not delay care, cause health care needs to go unmet, or cut utilization of hospitals, emergency departments, or operating rooms. So reports the Center for Studying Health System Change in a study of 35,000 nonelderly, privately insured Americans, conducted between 1995 and 1997.

Michael S. Wilkes and colleagues conducted a content analysis and found that 40% of DTC ads included claims of "innovativeness," even though, observe the researchers, "when it comes to drugs, what is new is not necessarily better and could even be more risky."



Dr. Wilkes et al. observe that DTC advertising works, which is why the manufacturers spent about \$2 billion last year on this approach. The effects on the physician-patient relationship have yet to be studied in depth. But the writers worry that patients influenced by DTC advertising may demand that physicians discuss brand-name drugs, trivial complaints, and formulary issues rather than symptoms, treatments, and disease prevention.

**Other Drug Problems.** Medication errors are discussed by Lee N. Newcomer, MD, of UnitedHealth Group. Dr. Newcomer laments the lack of incentives to reduce errors. He refers to a Boston study, previously reported in *JAMA*, in which a computerized physician order-entry system produced only five errors per 1,000 dosages, compared with a rate of 11 errors per 1,000 produced by a team consisting of a physician, pharmacist, and nurse. He calls on the federal government to mandate a computer order-entry system for Medicare.

**Medicare Benefit.** Emphasized in *Health Affairs* is the question of how to structure a Medicare prescription drug benefit. President

Clinton has proposed a drug benefit for all Medicare beneficiaries, but with a cap. Republicans have suggested subsidies for low-income beneficiaries.

Along with the president, Prof. Haiden A. Huskamp of Harvard Medical School and colleagues would like a single pharmacy benefit manager (PBM) in each Medicare market, just as there is one carrier per market. As opposed to a closed formulary, she prefers an incentive pricing arrangement in which the patient must pay the difference between the lowest-cost "reference drug" in a class and the drug that the patient purchases.

By contrast, Prof. Patricia Danzon of the Wharton School of the University of Pennsylvania would have beneficiaries choose a PBM from an approved list. Each PBM might develop three tiers of drugs in each class, with a different copay amount for each tier. In her view, this degree of competition and choice would prevent the strict budget pricing that could force manufacturers to curtail research.

Stanford University economist Mark McClellan and colleagues believe that the differences between the Democrats and Republicans can be bridged

through a restrained approach. A limited universal subsidy, he argues, would bring all beneficiaries into the fold, so that the per-person cost would be much lower than in a system that included only people with high drug costs.

Moreover, with only a limited subsidy, many employers and retirees would opt to retain more generous drug benefits, so that the private sector still would cover much of the elderly population. McClellan envisions a subsidy somewhere between 25% and 50% of a capped amount. This restrained approach may not please everyone, but, as Mae West said, "I like restraint, if it doesn't go too far."

**Drugs and AIDS.** *Medicine & Health Perspectives* quotes activists as faulting Mr. Clinton for skimping on AIDS funding for Africa. There, speaking of cost-effectiveness, pediatric HIV cases can be prevented at a cost of \$40. Several manufacturers are providing assistance.

**Problems with an HMO?** MSNJ members are invited to rate HMOs in a survey posted on the Medical Society of New Jersey's reformatted Web site, [www.msnj.org](http://www.msnj.org). Vote early.



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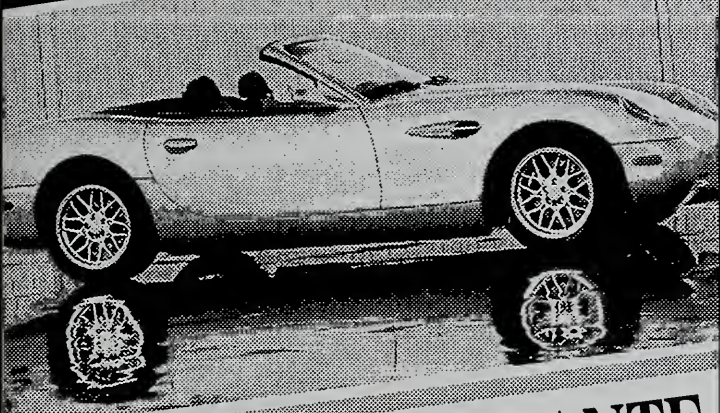
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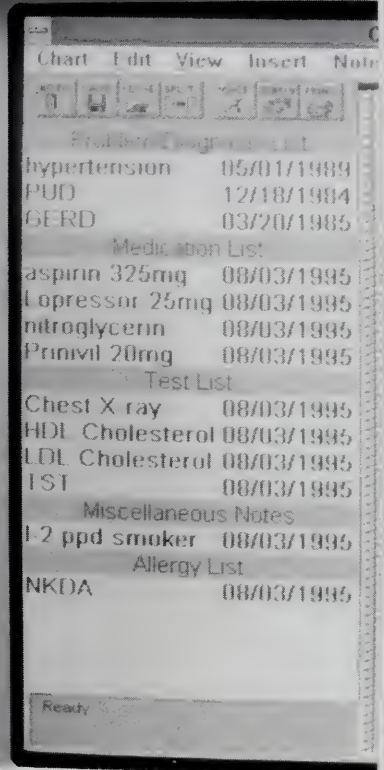
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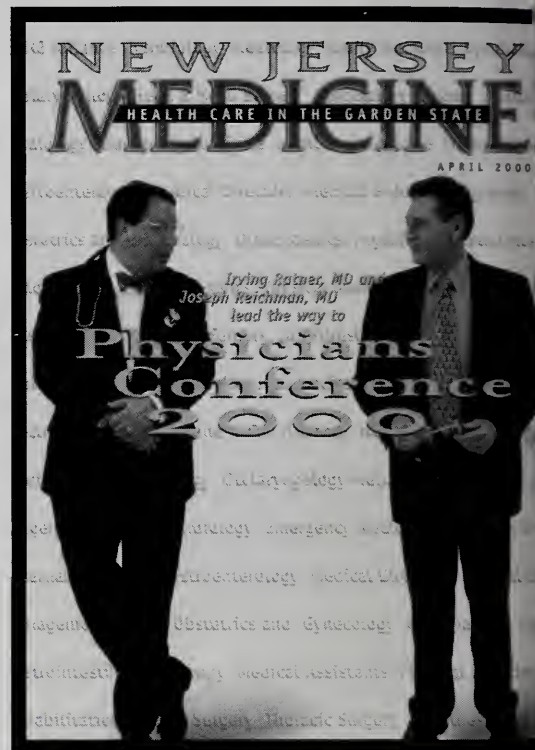
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## PHYSICIANS CONFERENCE 2000

*"We must all hang together, or assuredly we shall all hang separately."* Benjamin Franklin to others at the signing of the Declaration of Independence

The crises facing the practicing New Jersey physician have grown more acute over the past several years. Yet, in response to these crises, physicians have become less involved and less engaged and have an almost defeatist attitude toward the very processes that can help solve their problems. Membership in organized medicine, contributions to political action, and physician involvement in professional areas have dramatically declined. If we are to begin to solve these problems, we must all "hang together."

About two years ago, the concept for this conference was born. The need to bring all of the physicians of New Jersey together was obvious. But how were we going to do this? The Medical Society of New Jersey and the Academy of Medicine of New Jersey represented the largest number of practicing physicians in an organized structure. Thus was born the partnership to create Physicians Conference 2000. We wanted to reach out much further, however, than the membership of these two societies. To enjoin all of the licensed physicians, residents, and medical students, we enlisted the help of hospitals, medical schools, and other organizations. The result of this effort was the creation of one of the largest physician conferences in the country.

To bring all of these physicians together, three underlying themes were developed. First, we wanted to create an educational program, which would be of value to both the generalist and the specialist. Second, we wanted to give physicians an exposure to the political arena both in New Jersey and on the national level, hoping that ultimately physicians would become unified in a political agenda. Finally, we wanted to create a social environment where physicians and their families would be able to relax, network, and come to the realization that we have more in common with each other than we have differences. All of this, and more, will make up Physicians Conference 2000.

The continuing medical education (CME) program is enormous. More than 35 societies participated in crafting an educational program with more than 70 multidis-

ciplinary and specialty-specific workshops. An individual attending the conference will have the opportunity to earn as many as 17 category I CME credits. In addition, the general sessions will be both informative and thought provoking. On Friday, well-known NBC medical correspondent Bob Arnot, MD, will speak on "The Media Influence on Patient Behavior." On Saturday, bestselling author Richard Preston, PhD, will speak on "The Cobra Event: On the Trail of Biologic Terrorism."

The traditional House of Delegates of MSNJ and the New Jersey Academy of Family Practice will be held under the conference umbrella. In addition, the physician's public affairs seminar will be held on Friday. Ranking members of New Jersey's assembly and senate will be present for this event. The seminar will allow the conference participants to interact with our legislators to articulate the legislative needs of the physician community and our patients. This poses a golden opportunity for us to interact on a one-on-one situation with our legislators. Commissioner Christine Grant of the New Jersey Department of Health and Senior Services will address the convention on Sunday. On the national scene, we will have Greg Ganske, MD (R-IA), a leading physician and patient advocate in Congress, with us. Several other national political figures have tentatively accepted invitations; however, due to the current presidential primary races, they are not able to give a firm commitment as of this writing.

The convention exhibit hall will contain more than 200 exhibitors. The MSNJ's presidential gala honoring its incoming president, Walter J. Kahn, MD, promises to be an elegant evening. Dr. Kahn will welcome all of the respective societies and their members. The Peter Duchin Orchestra will provide music for the evening. Atlantic City is a wonderful resort town. It has much to offer: casinos, golf, tennis, the boardwalk, and the beach. Trips to historic Victorian Cape May are planned.

As you can see, Physicians Conference 2000 promises to be an exciting event. Think how effective we would be if all of us could work as a team. Much of our divisiveness occurs because of a lack of understanding and poor communication. If only we could solve these problems! I believe that Physicians Conference 2000 is the first step toward that goal. I hope to see you in Atlantic City.

**Joseph H. Reichman, MD**



## A SHOW OF UNITY

We have entered the countdown to the *Physicians Conference 2000—Advancing the Practice*. The intention of this event remains as strong today as during its conceptual origins—to bring together physicians from around the state to learn, network, and establish new directions for our profession.

Thirty-five specialty societies and medical organizations have come together to produce the *Physicians Conference*, with programs that transcend specialty boundaries and foster physician unity. In addition, we also offer special opportunities for the medical office staff who organize and run our practices as well as the residents and medical students for whom we pave the way.

The changes occurring in medicine today challenge us to remain current with new technologies and

treatments, while coping with the outside pressures bearing on the physician community. More than ever, we must work together to meet these challenges.

Advocacy is a key component of the *Physicians Conference*, as we create the venues and visibility needed to advance our profession. The strides made in improving the current health care environment will bring about a better future for physicians and patients.

So join us in a show of unity at *Physicians Conference 2000—Advancing the Practice*. You will not regret being a part of this groundbreaking event.

**Irving P. Ratner, MD, President**  
**Medical Society of New Jersey**

**John W. Sensakovic, MD, PhD, President**  
**The Academy of Medicine of New Jersey**

## THE IMPORTANCE OF COMMUNICATION

In August of 1999, when confronted with the news of a life-threatening disease affecting the residents of neighboring New York City, I rapidly assembled the staff of the DHSS and contacted sister state departments to decide how best to manage the public health threat posed by a suspected arbovirus. Working with the scientists at CDC, the New York City and State Departments of Health, the NJ Departments of Agriculture and Environmental Protection, Rutgers University, and the county and local mosquito commissions, we intensified our human and bird surveillance reporting protocols and advised a redoubled larval control program for mosquitoes. This issue of *New Jersey Medicine* provides an article describing those efforts and what is being done to prepare for a possible return of the virus.

The West Nile virus episode should instill a renewed commitment and sense of urgency among New Jersey physicians to evaluate their patients for diseases previously unidentified or newly emerging. It has become a cliché that any disease in the world is a plane ride away. This means that public health and

private practitioners must develop a reenergized agreement about when and how to report suspicious communicable or nonhuman vector-borne diseases immediately to the appropriate health officials.

Our experience with the West Nile virus underscored the need to strengthen public health communicable disease reporting. Hospitals and laboratories and local health departments are implementing the desktop electronic reporting needed to more efficiently report their findings. I hope more office-based physicians will follow. My goal is to develop an "e-mail health communicable diseases reporting system" that has a user-friendly single portal of entry for doctors, hospitals, laboratories, and health officers. My aim is improved feedback to clinicians.

Our near-future goal is to rely more on the Internet before, during, and after disease outbreaks in addition to the traditional reporting methods of phone and fax.

**Christine Grant**  
**Commissioner, Department of Health and Senior Services**

## REFLECTING WITH DR. IRVING RATNER

If one wanted to choose a clinician to be a spokesperson for public health, Dr. Irving Ratner would be ideal.

An orthopaedic surgeon who has a passion for tobacco control, Dr. Ratner talks about preventing children from smoking and getting adults to quit as if he were discussing how to fix a broken hip, has an understanding of the magnitude of the monies needed to measure up to the billions of dollars the tobacco companies spend in advertising, and suspects that the tobacco companies hide information from the public. He understands how difficult it must be to stop smoking once you're hooked and that smoking is a disease, an addiction.

Dr. Ratner wants the population of the state to have access to health care and has confidence in the physicians of New Jersey to deliver that care in the best way they know how. He wants the managed care organizations to reimburse the providers fairly and in a timely manner and wants them to be accountable for themselves and to establish a guaranty fund like other insurers.

Dr. Ratner wants MSNJ to meet the needs of many different kinds of physicians and feels that if medical students are offered membership they may stay members when they graduate. He thinks that physicians have important messages to deliver on behalf of their patients and if they are united their voice will be more meaningful.

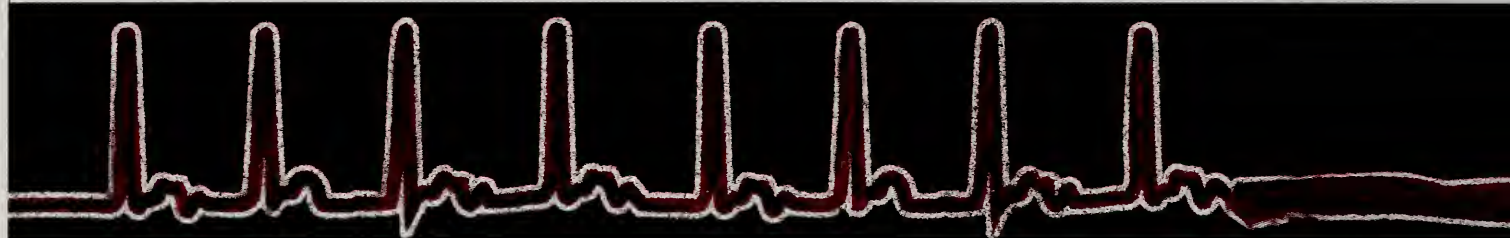
Most of all, Dr. Ratner believes in relationships—that if one meets the other party openly, honestly, and with good intentions something positive will happen. Dr. Ratner is leaving the presidency of MSNJ, but he is not leaving it to others to fulfill his vision for a better system of care. He will be there to continue the dialogues and make his points in the debates that follow.

An interview with Dr. Ratner exploring all these topics appears in this issue.

**Leah Z. Ziskin, MD**



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# F.Y.I.

## PEOPLE IN THE NEWS



Alison Grann, MD

**Alison Grann, MD,** has joined Saint Barnabas Medical Center's department of radiation oncology. Dr. Grann comes to Saint Barnabas from Memorial Sloan-

Kettering Cancer Center in New York.



Nilesh J. Patel, MD

**Nilesh J. Patel, MD,** has been named chair of the department of anesthesiology at Monmouth Medical Center, an affiliate of the Saint Barnabas Health Care System. He

has been a member of the medical and dental staff since 1987.



Richard A. Menghetti, MD, MS

**Richard A. Menghetti, MD, MS,** medical director of the department of radiology at Shore Memorial, has been elected president of the hospital's medical staff executive committee

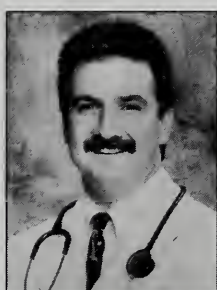
for 2000. Dr. Menghetti joined Shore Memorial as a staff radiologist in 1988 and became division director in 1992.

**Wendy McBair, RN, MS, CHES,** director of the William and Elizabeth Stretch Center for Arthritis Treatment at Virtua Health, received the Quality of Life award from the National Arthritis Foundation.



Larry Bologna

**Larry Bologna,** director of laboratory services at The Valley Hospital, has been named a Fellow in the American College of Healthcare Executives.



Douglas J. Borkowski, MD

**Douglas J. Borkowski, MD,** medical director of the HealthNet Medical Group's Riverdale practice, has been accepted by the National Registry of Who's

Who as a life member in recognition of exemplary service to the community and his profession.

The department of anesthesiology at Capital Health System recently welcomed five anesthesiologists and four certified nurse anesthetists to its staff. They are: **Joseph Agnello, MD; Gary Buck, MD; Edgardo Lachenal, MD; Phillip J. Mosca, MD; Kenneth Marshall Reid, MD; Theresa Campagna, CRNA; Mary De Rose, CRNA; Teresa Greenhalgh, CRNA; and Barbara Kuti, CRNA.**

**Gurston Turner, PhD,** after 25 years with the FDA, has joined Theradex in Princeton NJ, as director of clinical trials integrity in the quality assurance group, taking part in field audits of oncology clinical trials in North America and overseas.

## HEALTHCARE FOUNDATION OF NEW JERSEY AWARDS GRANT TO OVERLOOK HOSPITAL

Overlook Hospital has received a grant of \$124,000 from the Healthcare Foundation of New Jersey to create a palliative care program, "Care 2000." The grant supports an in-house palliative care consultation team and a training program for Overlook nurses and all other staff members who have direct contact with patients. Overlook physicians receive training through Education for Physicians on End-of-Life Care, or EPEC. The Department of Pain Medicine and Palliative Care of Beth Israel Medical Center in New York supported the grant application and is collaborating with Overlook to develop its program and conduct research. For more information, telephone (908) 522-2142 or e-mail [janina.scheytt@ahsys.org](mailto:janina.scheytt@ahsys.org).



## **THE SHARING NETWORK AWARDS NEW JERSEY NAACP**

The New Jersey Organ and Tissue Sharing Network has recognized the Rev. William H. Rutherford, director of the New Jersey division of the NAACP, for the group's role in expanding organ donation awareness within New Jersey's African-American community. In 1999, 444 life-saving transplants were performed, the most transplants ever performed in any year in New Jersey, and partnerships between local NAACP chapters and the Sharing Network played an important part in increasing donation rates. For more information, telephone (800) SHARE-NJ or visit the Web site at [www.sharenj.org](http://www.sharenj.org).

## **CAPITAL HEALTH SYSTEM BEGINS FAMILY SUPPORT SERVICES PROGRAM**

Capital Health System has received \$400,000 to implement a program that will provide crisis prevention and intervention services to Mercer County youth at serious risk for dangerous behaviors. The state legislature awarded the grant to Mercer County, which presented the funds to the Mercer County Traumatic Loss Coalition. Capital Health System was chosen by the coalition to implement the program. Karen Copeland, RN, has been appointed supervisor of the new prevention program, Family Support Services. For more information, telephone (609) 394-6091 or e-mail [cdeblasio@chsnj.org](mailto:cdeblasio@chsnj.org).

## **SHORELINE BEHAVIORAL HEALTH CHANGES NAME**

Shoreline Behavioral Health in Toms River has changed its name and has become the core of the new statewide Saint Barnabas Behavioral Health Network. It will now be known as the Saint Barnabas Behavioral Health Center. For more information, call (732) 914-3805.

## **CHARTMAKER SELECTED BY MSNJ**

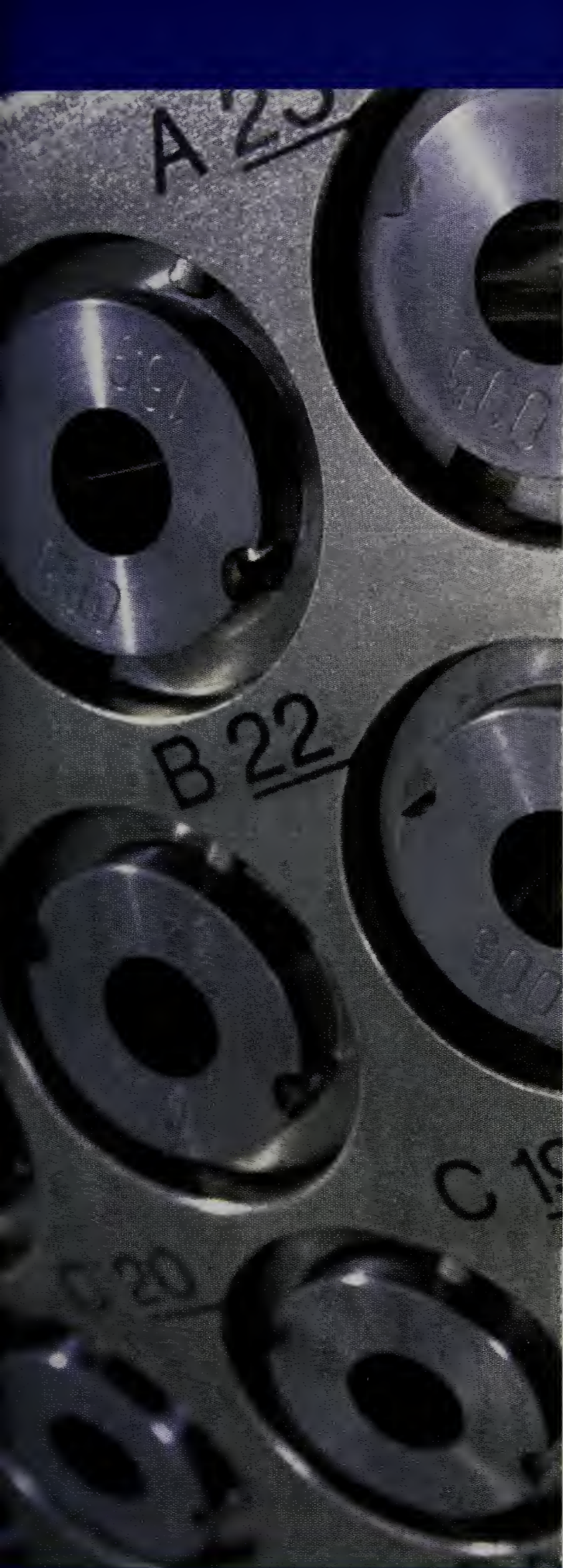
MSNJ members can now purchase the ChartMaker Computerized Patient Record System software at special discounted prices. ChartMaker is an MS-Windows NT-based system designed to produce legible, detailed patient care charts to help physicians comply with the Health Care Financing Administration's evaluation and management (E&M) guidelines by eliminating illegible, handwritten records. Information entry does not require typing; it can be accomplished through customized practice templates, pen-based computing, Dragon NaturallySpeaking voice recognition software, or dictation and transcription. For more information, contact Medical Information Systems, Inc., telephone (610) 768-9030, fax (610) 768-9519, e-mail [jocerra@chartmaker.com](mailto:jocerra@chartmaker.com).

## **2000 NURSE OF THE YEAR AWARDS**

kforce.com HealthCare is now accepting nominations for its 2000 Nurse of the Year Awards, a national program to honor registered nurses and LPN/LVNs who have repeatedly gone beyond the boundaries of their job descriptions in terms of community outreach and patient care. Applications for the awards are being accepted through July 31, 2000. The winners will be announced during separate ceremonies in October. For more information on the awards program or to obtain an application, visit the About Us section on [www.kforce.com](http://www.kforce.com) or telephone (877)-687-7309 or e-mail [nurse-award@kforce.com](mailto:nurse-award@kforce.com). kforce.com is a Web-based specialty staffing firm in health care, pharmaceutical, and other specialty skill areas.







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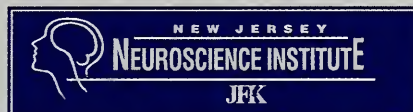
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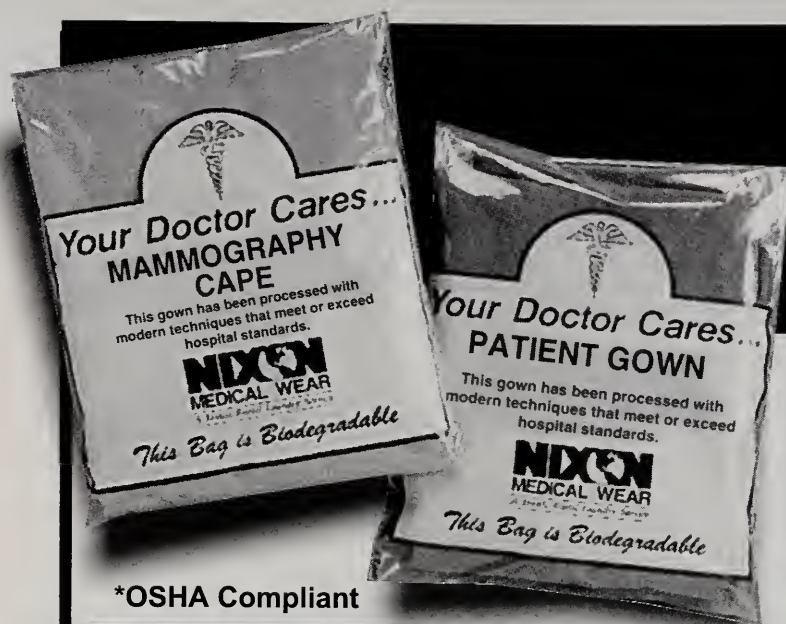
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*A Talk With*

# Irving Ratner, MD

*207<sup>th</sup> President of MSNJ*



**N**ew Jersey Medicine (represented by Associate Editor Leah Z. Ziskin, MD) talked with Irving Ratner, MD, in his office about his term as the 207<sup>th</sup> president of MSNJ and what has been accomplished and what challenges remain.

**New Jersey Medicine:** When you first took office last May, you told *New Jersey Medicine* that your highest priority was tobacco cessation. What have you and the society accomplished to further tobacco cessation during your term in office?

**Dr. Ratner:** Tobacco control is the most important public health issue that we face, and tobacco addiction is an illness that has been present in this country for centuries. We need to be bold enough to take the bull by the horns and put in place smoking policies and programs that effectively correct the problem. We have an opportunity to do it right, but if we don't do it right now, we're going to lose the chance.

This is why I must express some disappointment with Governor Whitman's budget for the use of NJ's share of the tobacco settlement. I would like to see \$57 million dedicated to these programs, which was the original amount proposed and is in keeping with the recommenda-



tion of the Centers for Disease Control and Prevention.

**NJM:** The governor has also proposed allocations for the \$300-million installment that New Jersey expects to receive in the state's 2001 budget. What do you think of her allocations thus far, one-third to provide health insurance for low- and middle-income workers, one-third on school construction, \$50 million on the HMO guaranty, and \$30 million on tobacco control programs?

**Dr. Ratner:** I understand the governor's desire to use some of the tobacco settlement money for school construction and other related issues, yet I would prefer that all of it be allocated for health costs or health problems.

The use of the money for non-health issues detracts from our ability to deal with health problems. Children are being enticed and pressured into smoking. And there are many, many adults who are having tremendous difficulty in breaking their tobacco addiction. They're going to need a lot of help from their physicians, counselors, and medication to be able to stop smoking. So this is a long-term project.

**NJM:** How do you actually counsel your patients about smoking? What points do you make?

**Dr. Ratner:** From an orthopedic surgeon's point of view, in particular, we now know that smoking damages the discs in the spine. The nicotine causes vascular compromise and endothelial dysfunction and

damages the microcirculation, which can lead to degeneration of the disc and all of the ills that go with it, including disc herniation. I spend a great deal of time with my patients who are smokers and who come in with back problems. I counsel them on the importance of giving up cigarettes. I would say that 99% of the people who come into the office do not understand that tobacco can damage their spines.

**NJM:** The condition you described has not been in the public literature. Why not?

**Dr. Ratner:** It has not been in the public literature, but it is in the scientific literature. Of course, the tobacco industry has made no effort to disseminate this information. There is also a known relationship between smoking and osteoporosis since calcium loss is affected. As a physician, I have been extremely

vocal not only in my practice but in my social circles and in the hospital with regard to smoking cessation because of the role of smoking in heart disease, hypertension, strokes, lung cancer, and all of the ensuing complications. I believe that all physicians have a responsibility to counsel their patients and recommend that they stop smoking. I believe it remains the responsibility of the family practitioner or the internist, who manages the patients on a day-to-day basis, to prescribe the help they need to quit.

Tobacco is a serious addiction—it is very difficult to beat. Studies have shown that the more often individuals try to quit smoking, the higher the chance they will be successful. So that the first failure, or the second, or even the third, is no reason to give up.

**NJM:** In addition to the progress achieved in tobacco control, what were the society's major accomplishments during your term?

**Dr. Ratner:** There were several major accomplishments during this past year. Let me start with the Physicians Conference.

### Physicians Conference

The Physicians Conference 2000 will bring together 32 specialty societies, the MSNJ, the Osteopathic Society, and the Academy of Medicine; physicians who are members of the MSNJ and those who are not; those who are in private practice and those who are in industry and in teaching positions. This is unprecedented on the East Coast of the US.

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MOST MONEY TO INITIATE  
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AND SCHOOL PROGRAMS,  
AND WE'RE NOT GOING TO  
BE ABLE TO DO IT  
EFFECTIVELY WITH THE \$30  
MILLION THE GOVERNOR  
HAS ALLOCATED FOR THESE  
PURPOSES.

## Business Programs for Physicians and Staff

In my inaugural address, I recommended to the physicians of the state that they become business-oriented individuals rather than simply clinicians. I indicated that the only way to deal with managed care organizations effectively was to emulate their business orientation. We have succeeded in getting programs initiated not only for physicians but also for their practice managers and their staff.

### Opening a Dialogue with Managed Care

With the assistance of the Department of Health and Senior Services (DHSS) Commissioner, Christine Grant, we have initiated a dialogue with Aetna-US Healthcare Prudential. In response to this merger, certain requirements were put forth, including that the HMO open a dialogue with physicians and a dispute resolution system. We have begun to address the problems related to formularies and the deprivation of certain drugs for patients. We have not yet gotten into the financial aspect of the managed care relationship, but we are getting close to being able to deal with it. The bottom line is the protection of the patient. If quality of care is preserved and the patients are not deprived of appropriate medical care, physicians can work well with the managed care organizations. The secondary issue, and it always remains secondary to patient well-being, is the reimbursement to physicians.

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TOWARD THAT END.

### Adequate Reimbursement for Health Care Providers

We remain concerned about managed care organizations unilaterally lowering reimbursements, altering contracts without physician input, and about the dispute resolution system mandated by the attorney general.

As a result of Medicare cuts and the lowering of reimbursement by managed care, there is no question that not only hospitals but physicians have been seriously financially disadvantaged. Many physicians have left practice prematurely, and we have lost good doctors in the state. Physicians have laid off staff and condensed their offices—instead of having three separate offices they have only one—to preserve resources. This is clearly and directly a product of managed care systematically reducing reimbursements to

physicians to unacceptable levels. This is an issue that we are prepared to address with the managed care organizations, not only Aetna-US Healthcare Prudential, but all of them. This will be an ongoing task that I intend to participate in even after I leave the presidency.

### NJ KidCare

We are supporting the NJ KidCare program, which has enrolled just more than 30% of the eligible children in the state. MSNJ is working through the physicians—in their offices and with the Alliance—to enroll more children in the program. The governor has increased the eligibility income to 350% of the poverty level. The application forms are streamlined and written in every conceivable language. We're trying to remove further barriers to enrollment and improve the access to care that the KidCare program offers.

### Increasing MSNJ Membership

To increase the membership in the MSNJ, we have offered membership to every medical student in the state free of charge. We now have an active medical student section in the society, which has expanded dramatically. This was one of the projects that I initiated when I first became president, and I was fortunate enough to see it come to fruition. We have created a faculty section in the medical society with representation in the House of Delegates with the expectation of ultimately providing a faculty seat on the Board of



Trustees and a vote for academically based physicians.

### Improved Relationship with Government Offices

We have established and maintained a very close working relationship with the governor's office, the legislature, and in particular the DHSS and the Department of Banking and Insurance that will definitely and positively affect the delivery of medical care. MSNJ has been encouraged to come forward with ideas and suggestions and in some cases, when necessary, criticism. But it's been done in a very friendly and constructive way.

### Other Accomplishments

We have new and improved relationships with the Board of Medical Examiners (BME) and have established an open dialogue with the director of the BME and the officers. We are involved in the BME's effort to equate criteria for licensure between international and US medical school graduates. We are also participating in a project that will lead to continuing medical educational requirements for all physicians as a condition of licensure.

**NJM:** We have all been affected this past year by the dissolution of one of the largest HMOs in this state, HIP. Tell us about the bill that proposes that the HMOs contribute to a guaranty fund and what your position or the society's position is on this bill.

**Dr. Ratner:** When the managed care industry was born during the

1970s, it took the form of health maintenance organizations. They were not considered to be insurance companies, but they now function as insurance companies. Every sector of the insurance industry in NJ has a guaranty fund, a reinsurance authority, to back up that company or that group of companies in the event that one or more of them fail. For several years MSNJ has advocated that the managed care industry be required to guarantee itself, just the same as the other sectors of the insurance industry do. A nominal amount of money, perhaps 1% of the profits, could be put into the fund, which would not hurt the managed care organizations, because most of them are financially sound and can afford to do this. We also feel very strongly that the cost of this contribution should not be passed on to the consumer or taken out of

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the pockets of the providers. We think that there is a chance that other organizations will fail, and we do not want ever again to go through the gut-wrenching aggravation of the HIP failure with regard to the patients and the physicians.

Before she became a Supreme Court Justice, Commissioner LaVecchia instituted new controls on the managed care industry through regulation that would enable the regulators to identify a company in trouble and work to rectify its financial woes before it was on the verge of bankruptcy. In the ideal world, this regulatory change would negate the need for a guaranty fund. But we don't live in an ideal world, and because there is a risk involved for the patients who are members of these organizations, the guaranty fund should be in place. If over a period of years, the new regulations prove to be strong enough and the companies remain sound, perhaps there would be some provision for sun-setting the guaranty fund and withdrawing it. The legislature should act to establish the guaranty fund, in this session or in a future session.

**NJM:** You've mentioned some very significant accomplishments. What important goals remain to be completed?

**Dr. Ratner:** It would have been very rewarding to have seen a change in the attitude of the managed care organizations with regard to their withholding of care. For example,

pushing people out of hospitals prematurely, or this formulary business, where patients are deprived of needed medications because of cost.

We still need to deal with the financial relationships between managed care organizations and physicians. One of the major problems is reimbursement. The prompt-payment legislation that was signed into law by the governor on December 28, 1999, will certainly help a great deal. But there is still a terrible problem with the managed care organizations balancing their books on the backs of doctors and patients. I truly hope to see steps taken to reverse this.

The tobacco settlement is of concern to me. I would very much like to have seen the decision to allocate 20% to 25% of the tobacco settlement to tobacco cessation programs carved into stone by the end of my presidency.

I also would have liked to have seen some guarantees of coverage for uncompensated care for physicians in hospitals. I know we're working toward that end, but we're crawling instead of running. We have situations where hospitals and physicians are providing billions of dollars of care for which they are never reimbursed.

**NJM:** This is a good time to ask what advice you have for Dr. Walter Kahn as incoming president.

**Dr. Ratner:** The most important advice I can give Walter Kahn is to maintain the momentum that we have established in the good rela-

AS A RESULT OF MEDICARE CUTS AND THE LOWERING OF REIMBURSEMENT BY MANAGED CARE, THERE IS NO QUESTION THAT NOT ONLY HOSPITALS BUT ALSO PHYSICIANS HAVE BEEN SERIOUSLY FINANCIALLY DISADVANTAGED.

tionships with the administration and legislature. I am firmly committed to working with all these individuals, and I know that Walter Kahn will continue to do the same and that the patients and the physicians in this state will benefit greatly.

**NJM:** Can you reflect on the two or three major issues that physicians will face in the coming years that you haven't already covered?

**Dr. Ratner:** There are a few other issues that we need to deal with, which are taking longer to accomplish. The state action doctrine relates to physicians' ability to negotiate with the managed care organizations in a legal fashion—for example, breaking down the antitrust regulations that hinder physicians from negotiating with all forms of payors. We also need to support the Campbell bill, which on the federal level will eventually allow physicians to negotiate.

We should pressure Congress to pass the Patient Bill of Rights. We are hoping that the conference committee will produce a bill that will be pretty close to the original Norwood-Dingell bill passed by the House of Representatives. This is another issue where patients will benefit tremendously, and managed care organizations will become more responsible to patients because they may have legal action taken against them.

I think these are the issues that will be very critical for physicians in the coming year.

**NJM:** Is there anything else you would like to include in this interview?

**Dr. Ratner:** I would like to express my appreciation and gratitude to the physicians, the staff, the counties, the members of all of the different sections of the administration that I've come in contact with, and the legislature. I would like to express my sincere debt of gratitude to those individuals for everything they've done for me personally during this year. It made my life as the president very easy. I would also like to express my appreciation to my partners in my orthopedic practice for giving me the ability to do all of this, and to my wife, Lynn, who supported me on those lonely nights when I was at meetings and away from the house, driving long distances to all corners of the state.

**NJM:** On behalf of MSNJ and *New Jersey Medicine*, thank you for a job well done.



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# PHYSICIAN'S PROFILE HELPS PATIENTS AND DOCTORS

Sen. Richard J. Codey

In the state of Massachusetts, consumers can find out important information about their doctors to help them with their medical decisions. Via the Internet, they can learn that the vast majority of medical professionals have outstanding backgrounds and care deeply about the best interests of their patients.

Here in New Jersey, consumers have no such recourse, but I serve as sponsor of a bill to give them that option. Called the Physician's Profile bill (S-575), my proposal would require the state to set up an electronic physician's profile of every doctor in the state.

This profile would include important information about every doctor, such as education, number

of years practicing, office location, office hours, medical specialty, and other relevant factors. It will help to match patients and doctors in ways that benefit both.

In Massachusetts, the Board of Registration in Medicine runs a Web site, [www.massmedboard.org](http://www.massmedboard.org), which features an option to access the physician's profile of every doctor in Massachusetts. Consumers and others in Massachusetts can find out a variety of information about doctors, including a physician's education and training, awards and publications, insurance plans accepted, and malpractice and disciplinary histories. I urge everyone in the medical community in New Jersey to visit this site and see what the future holds in store for us.

And make no mistake about it: having medical information on the Internet represents not only the future, but in some cases the present. *The New York Times* recently carried a front-page article that discussed how many patients now conduct medical research via the Internet.<sup>1</sup> The article quotes a Columbia University medical specialist as saying this represents "a massive revolution" in medicine.

I could not agree more. This same article quotes the head of the American Medical Association as saying, "I think this is the wave of the future." The AMA recognizes it, the state of Massachusetts recognizes it, and now New Jersey must also recognize it.

In the New Jersey Legislature, we have a vetting process, just as with



medical professionals. We address concerns that others raise. For instance, when my bill came before the Senate Budget and Appropriations Committee last year, a representative of the Medical Society asked that we include the number of malpractice awards in our bill; we took the Medical Society up on its suggestion and the bill that passed the Senate Health Committee in February now includes this provision. We remain open to further suggestions that will benefit patients and medical professionals.

I hark back to Massachusetts because of the forward thinking its medical society showed in taking the lead in 1996. After Massachusetts established its physician profiles, at least 10 other states have instituted their own provider profile. Patients already have access to a tremendous amount of medical information online; the *Times* article said the Internet contains more than 100,000 medical Web sites, on many of which patients can investigate medical conditions, treatment, and medicine. It's just a matter of time before someone provides online information about medical practitioners in New Jersey.

So while my bill provides important information for the patient, it

**CONSUMERS AND OTHERS  
IN MASSACHUSETTS CAN  
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INFORMATION ABOUT  
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AND TRAINING, AWARDS  
AND PUBLICATIONS,  
INSURANCE PLANS  
ACCEPTED, AND  
MALPRACTICE AND  
DISCIPLINARY HISTORIES.**

also benefits doctors and other medical professionals by giving you an opportunity to detail important information about yourself and your practice to prospective patients. Thus, you can list all the awards and recognitions you and your practice have received over the years. You can provide your office hours, your areas of specialty, hospital privileges, faculty appointments, and national certification and accreditation.

To start off, the program would include just physicians and podiatrists, but we hope to expand it to include dentists, advanced-practice

nurses, physician assistants, optometrists, physical therapists, and chiropractors.

And, yes, the New Jersey Web site will list malpractice awards or potential disciplinary actions. But here's the point: people who know how to use the Internet well can probably unearth this information now anyway. And our profiles will reflect the quality of each profession and how awards fall within each category of medical practice.

So go to the Massachusetts Web site. Since Massachusetts has put its Internet program online, thousands of citizens have learned more about their doctors. The Massachusetts medical community stands behind their physician profiles. In the same way, the New Jersey medical community can play an equally important role in developing New Jersey's physician profiles.

This should result in a better doctor-patient relationship for all.

*Richard Codey, D-Essex, is the state senate minority leader and represents the 27th legislative district, which includes East Orange, Montclair, Orange, West Orange, and part of Newark.*

## References

1. Kolata G. Web research transforms visit to the doctor. *The New York Times*, March 6, 2000, p. 1.



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# FOCUS ON THE ACADEMY OF MEDICINE: COMMITMENT TO EDUCATION AND UNITY

THE COOPERATION BETWEEN THE MEDICAL SOCIETY OF NEW JERSEY AND THE ACADEMY OF MEDICINE OF NEW JERSEY IN DEVELOPING PHYSICIANS CONFERENCE 2000 CLEARLY UNDERSCORES THE EVENT'S GOAL—UNITY AMONG THE MEDICAL COMMUNITY.

*Robin Rapport*

"It was a natural step for the Academy of Medicine and MSNJ to take the lead roles for Physicians Conference 2000," says Charles Heitzmann, executive director of the Academy. The Academy has a long tradition of providing continuing medical education to physicians. Plus, it works closely with many specialty societies. These two factors—education and collaboration with the specialties—are the keys to a successful medical conference that is open to all New Jersey physicians.

Heitzmann feels strongly about the importance of Physicians Conference 2000. He sees it as an opportunity to work with physicians throughout the state, regardless of their specialty, toward common goals. One of the first challenges was to develop a program relevant to all physicians.

## **A Collaborative Effort**

"Over the past few years, a task force that included representatives of the Academy, MSNJ, and the participating specialty societies looked to create a comprehensive educational program—a concept that really took off," says Linda Bartolo, director of administrative services, AMNJ. "The group took into account not only the unique needs and interests of the participating specialties but also those pressing issues that face all physicians."

The result is "an exciting educational program that will have something for everyone," says Bartolo. In addition to offering specific programs for specialties, the conference includes plenty of multidisciplinary sessions on issues that affect the overall practice of medicine.

## **Continuing Education Credits**

AMNJ was instrumental in planning and organizing the programs, developing objectives, performing

needs assessments, obtaining the right speakers, and ensuring each course met the essential criteria for Category I designation. The Academy has been accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians, dentists, and other health care professionals since 1972. "The Academy has always been considered the educational arm of the Medical Society of New Jersey," adds Bartolo.

"The Academy plays the role of primary sponsor of much of the Continuing Medical Education (CME) courses in the state. We offer about 250 courses and seminars each year," says Heitzmann. In the process, the Academy is well aware of all the demands on physicians and on their time. That is one of the reasons why Heitzmann and his staff are so excited about Physicians Conference 2000.



"In one conference, physicians have more than 70 workshops and lectures at which they can earn up to 17 credit hours toward their AMA Physician's Recognition Award," says Mae Slobecki, AMNJ senior associate director of research and education. "The workshops and lecturers are excellent and present something of interest for everyone to attend."

"What's more, it's a bargain," says Heitzmann. "Sometimes doctors pay as much as \$300 to \$600 to attend a course out of state. Plus, they must pay for travel, rooms, and more if they bring their spouse. Here, we are staying in the state at a wonderful facility, and *all the CMEs* are included in the fee of \$199. Physicians who signed up early got an even better value." In addition, obtaining accredited CMEs has never been so important for physicians. "As an accrediting body, all of our programs and courses come under Category I, which is what physicians need. Most hospitals require a doctor to obtain 150 CME credits every three years. Many national specialties do as well, but not all." Now, however, a big change is occurring. "The State Board of Medical Examiners will soon require *all* physicians to have 150 hours every three years to maintain their license," explains Heitzmann.

### Working with the Specialties

Appropriate educational offerings for physicians, AMNJ has learned, are not always specialty-

specific. All physicians require information about the rapidly changing world of managed care and the political forces that affect it.

Similarly, physicians in multiple specialties are concerned about the topics addressed by some widely anticipated conference sessions. These topics include bloodless surgery, vertical HIV transmission, alternative medicine, and changes in primary care. Nationally acclaimed speakers will make all these presentations.

Today, the AMNJ provides varying levels of educational expertise and guidance and secretarial services to 39 organizations representing more than 10,000 New Jersey physicians and health care professionals.

FOR PHYSICIANS  
CONFERENCE 2000, THE  
AMNJ WAS INSTRUMENTAL  
IN PLANNING AND  
ORGANIZING THE  
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NEEDS ASSESSMENTS,  
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ESSENTIAL CRITERIA FOR  
CATEGORY 1 DESIGNATION.

This educational role casts AMNJ as the preeminent provider of CME in the state. Consequently, AMNJ physician leaders and staff are well-positioned to identify educational needs and determine how best to meet those needs.

Professional development of excellent CME programs is central to the Academy's mission.

This activity is fundamental to Physicians Conference 2000. Bringing physicians together to share information, problems, and goals is essential to unity in the profession. The conference will try to achieve this from an educational, political, and social perspective. Heitzmann says, "The idea behind the conference was to get all of medicine on the same page. We wanted to make it a megameeting. We said, 'Let's make it everyone's meeting to represent all of medicine. Let's get more people involved and go beyond politics and academics. Let's create a united front to the legislature.' This is the fruition of all of those discussions that began two years ago."

Heitzmann credits all his staff, particularly Linda Bartolo, Mae Slobecki, and Sondra Moylan (director of research and education), for doing an incredible job putting it all together. Bartolo sums it up: "It was a monumental task. But it will be well worth it."

*Robin Rapport is a freelance writer based in Trenton.*

# LOOKING TOWARD THE FUTURE: MSNJ VICE PRESIDENTS PREDICT CONFERENCE IMPACT

MEDICAL PROFESSIONALS AS WELL AS LEGISLATORS ARE CLOSELY WATCHING THE RESPONSE TO PHYSICIANS CONFERENCE 2000—THE GROUNDBREAKING STATEWIDE MEETING PLANNED FOR MAY 5-7, 2000 IN ATLANTIC CITY.

A SUCCESSFUL CONFERENCE MAY BE A POSITIVE CATALYST FOR CHANGE FOR MSNJ AS WELL AS FOR PHYSICIANS OF OUR STATE.

*Robin Rapport*

**B**oth Dr. Angelo Agro, currently first vice president of MSNJ who will become president in May 2001, and Dr. Robert Rigolosi, second vice president who will become president the following year, are optimistic about the impact of New Jersey's first annual meeting that includes MSNJ and the medical specialty associations.

## **The Need for a Unifying Conference**

"Over the past 10 to 15 years, physicians have come under the increasing pressure of being ruled by everyone else. Economics began to dictate what a doctor does," says Agro. "With that came the tendency to split apart, rather than unify. We lost focus as managed care, the legal

system, and the general erosion of authority tore doctors down. But it was like a pendulum that swung too far the other way. It made doctors into technicians who had no say. We were forced to think as business-people first.

"Now we are thinking as professionals and academicians—more like physicians in the old sense. We have come to realize that unity is pretty much essential for the survival of the profession. One of the things that will help is a conference like this. We can put aside some of our differences and come together for common interest," adds Agro.

Agro believes that Physicians Conference 2000 is a step in the

right direction. "We have been in niches too long. The conference will allow us to communicate and to unify. It will help us to speak with one voice—even if collectively we don't have a black or white opinion on everything. That will serve the profession better than anything I see coming down the road. Without unity, you don't get legislative relief, increase in membership, or the dedication of members in the Society."

Rigolosi agrees. "I would like to see this as an annual event. I'm hoping that this will improve MSNJ membership and help the different societies to unite so we can speak with a stronger unified voice. It will



mean a lot when we are trying to go to legislature." Moreover, Agro sees it as an opportunity to improve patient care. "It provides the framework so physicians can care for patients in the way they should care for them, not as dictated by other people or economics."

### Impact on Recruitment and Retention

From a recruitment and retention perspective, Rigolosi believes that the conference will have an impact in both the short and long term. "I am hoping that we can recruit people at the time of the conference as well as down the road. New physicians will come to this meeting and see what is available in this state."

Both Rigolosi and Agro believe that the conference has the potential to secure local, state, and regional attention. "In Bergen County where I am from, there is already a lot of enthusiasm to support and participate in the conference. Bergen County will support it 100%," says Rigolosi. Agro anticipates increased media attention as well. He says, "I don't know of others on the East Coast doing this. It brings together physicians and allows them to share ideas and realize they are not so far apart. It's a great catalyst that will promote and facilitate communications and cooperation. Right now, that is news."

The increased attention and, more important, the increased effectiveness of a more unified medical community will undoubtedly increase MSNJ membership and impact.

### Impact on the Medical Legislative Agenda

Rigolosi looks forward to a medical society that "can support the positions of different specialty societies and their problems as a more diverse and unified group. It would certainly make more of an impact from a legislative point of view. The more members we have in MSNJ, the greater the impact on the legislators."

"Legislators don't make the distinction among specialties," says Agro. "They want to think of medicine as a single entity and a single force. If we go to them with mixed messages, none of our messages will be heard clearly. There's no sense having three or four lobbyists on the same bill. There's no need for the profession to be fragmented in that manner."

### The Conference and Upcoming Presidents' Agenda

"I see the conference as a first step toward meeting the challenges facing the health care profession. While the AMA tried to unite physicians in the past, it was unsuccessful because it attempted to do it from the top

down," explains Agro. "Instead, we're building up from the grass roots, involving all the specialties. When you start with the grass roots, the county societies and specialty societies can come together and unify as a state. Only then does it become possible to have states get together regionally and unify into a more cohesive AMA or national federation," says Agro.

Agro believes that the conference "is the most tangible, practical way to preserve the profession." He hopes the conference will establish a precedent and plans "to channel this energy into something very productive. While it takes time for opinions to change and paradigms to shift, we have been under pressure as a profession for some time now. It's time to be proactive."

Rigolosi envisions a medical society that represents 33 or more specialties sharing ideas and perspectives and helping each other achieve mutual goals. He believes that "there is value in numbers and in speaking with one voice. If membership improves, as I hope it will, things will get very interesting. With greater membership, there's more input, more participation, and more support for bills, and more success."

"While I cannot predict the major issues during my presidency in 2002," says Rigolosi, "unity will play a major role in obtaining better health care for our patients. Isn't that what it's all about?"

*Robin Rapport is a freelance writer based in Trenton.*

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PRETTY MUCH ESSENTIAL  
FOR THE SURVIVAL OF THE  
PROFESSION.

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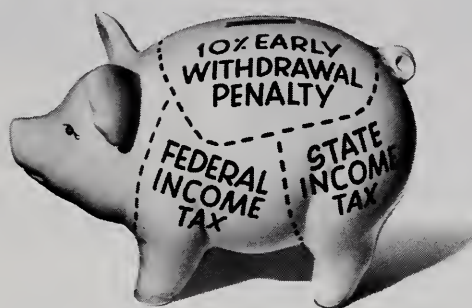
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*Advancing the Practice*

# Physicians Conference 2000

## WORKSHOPS & PROGRAMS

*"Advancing the Practice" involves learning more about the range of issues facing physicians, medical office staff, and allied health professionals ... from asthma to vaccines and from politics in the medical office to those found in Trenton and Washington DC. Review the following list of programs, workshops, and lectures to start planning your time in Atlantic City at the exciting Physicians Conference 2000.*

### Thursday, May 4

|                                       | 7 AM | 8 | 9 | 10            | 11 | 12 PM | 1 | 2                      | 3 | 4 | 5 |
|---------------------------------------|------|---|---|---------------|----|-------|---|------------------------|---|---|---|
| MSNJ House of Delegates               |      |   |   | First Session |    |       |   |                        |   |   |   |
| MSNJ Golden Merit Awards and Luncheon |      |   |   |               |    |       |   |                        |   |   |   |
| MSNJ Reference Committees             |      |   |   |               |    |       |   | A-1:30; B-2:15; C-3:00 |   |   |   |
| AFP House of Delegates                |      |   |   |               |    |       |   |                        |   |   |   |



# Friday, May 5

## SESSION I: 8:15 - 9:15 AM

- *Interactive Health Communications: Using New Media to Reach Patients* – Victor Strecher, PhD

## SESSION II: 9:30 - 11:00 AM

- *Advances in Kidney/Pancreas Transplant* – Shamkant P. Mulgaonkar, MD
- *Warning: Managed Care May Be Dangerous to a Physician's Health* – John P. Docherty, MD
- *The Demise of the Volunteer Medical Staff* – Todd C. Brower, Esq. & John D. Fanburg, Esq., Brach, Eichler, Rosenberg, Silver, Bernstein, Hammer & Gladstone
- *Conscious Sedation: Update 2000* – Thomas W. Cutter, MD
- *The Evaluation of the Patient With Medical or Surgical Breast Symptoms* – Panel Discussion: Primary Care – Randi Protter, MD; Radiology – Susan Greenstein Orel, MD; Surgery – Nancy Elliott, MD; Pathology – Nicola Barnard, MD
- *Emerging Options in the Diagnosis and Management of Peripheral Vascular Disease* – James B. Alexander, MD; John J. Castronuovo, Jr, MD; Lowell S. Kabnick, MD

### PHYSICIAN/OFFICE STAFF

- *Regulatory Mania in the New Millennium* – Denise L. Sanders, Esq., Kern Augustine Conroy & Schoppmann, P.C.
- *Preparing for a State Medical Board Visit* – Robert J. Conroy, Esq., Kern Augustine Conroy & Schoppmann, P.C.

## PLENARY SESSION

11:00 AM – 12:30 PM

**WELCOME/KEYNOTE: DR. BOB ARNOT**  
**"Media Influence on Patient Behavior"**

## SESSION III: 1:30 - 3:00 PM

- *Psychopharmacology: What's New & Designer Drugs* – John P. Docherty, MD

- *Type 2 Diabetes: New Technologies* – Jay A. Sher, MD
- *Allergy and Asthma Update: The End of Sneezing and Wheezing* – Michael A. Kaliner, MD
- *The Future of Physician Organizations* – Burton Eichler, Esq., Joseph M. Gorrell, Esq., Susan Y. Leonard, Esq., Brach, Eichler, Rosenberg, Silver, Bernstein, Hammer & Gladstone
- *Pregnancy, Pediatrics, & HIV Infection: Guidelines for Your Practice* – Arlene D. Bardeguez, MD & George D. McSherry, MD
- *Women's Health Issues: Recognition and Treatment* – Gerson Weiss, MD
- *Death & Dying: Easing the Pain* – Panel Discussion: Paul W. Armstrong, Esq.; Susan M. Bauman, MD; Joseph F. Fennelly, MD; Teresa M. Schaer, MD
- *Pneumococcal Infection: A Disease in Need of Prevention* – Mark I. Zimmerman, MD
- *Risk Management* – Patricia Costante & Lisa Kramer – MIIX Group of Companies

### PHYSICIAN/OFFICE STAFF

- *Learning How to Play Well in the Sandbox* – Steven I. Kern, Esq., Kern Augustine Conroy & Schoppmann, P.C.
- *Medicare Reimbursement: What is New One Year Later* – Gail Rounds, Manager, Empire Medicare Services

## SESSION IV: 3:30 - 5:00 PM

- *Hepatitis C & HIV Coinfection* – UMDNJ-AIDS Education & Training Center – Jihad Slim, MD & Joseph R. DePasquale, MD
- *Advances in the Evaluation and Management of Sleep Disorders* – Karl Doghramji, MD
- *Rheumatoid Arthritis: It Shouldn't Hurt to Move* – Elliot Rosenstein, MD
- *Therapeutic Options for the Patient in Chronic Pain* – Panel Discussion: Physical Medicine & Rehabilitation – Lauren Shaiova, MD; Psychiatry – Thomas Newmark, MD; Anesthesiology – John Secoy, MD

### PHYSICIAN/OFFICE STAFF

- *OSHA Highlights* – John M. LaCarrubba
- *Fraud and Abuse* – Michael J. Schoppman, Esq., Kern Augustine Conroy & Schoppmann, P.C.
- **Physicians Public Affairs Seminar**  
**NJ Senate Health Committee Hearing: State Action Doctrine**  
**3:30 - 5:00 PM**

# Friday, May 5

|                                        | 7 AM | 8       | 9              | 10            | 11 | 12 PM | 1 | 2 | 3 | 4 | 5 |
|----------------------------------------|------|---------|----------------|---------------|----|-------|---|---|---|---|---|
| MSNJ House of Delegates                |      |         | Second Session |               |    |       |   |   |   |   |   |
| Registration                           |      | All Day |                |               |    |       |   |   |   |   |   |
| Exhibits Grand Opening                 |      |         |                | Exhibits Open |    |       |   |   |   |   |   |
| Plenary Session: Dr. Bob Arnot         |      |         |                |               |    |       |   |   |   |   |   |
| Breaks, Lunch provided in Exhibit Hall |      |         |                |               |    |       |   |   |   |   |   |
| Workshop Session 1 & 2                 |      |         |                |               |    |       |   |   |   |   |   |
| Workshop Session 3                     |      |         |                |               |    |       |   |   |   |   |   |
| Workshop Session 4                     |      |         |                |               |    |       |   |   |   |   |   |
| Physicians Public Affairs Seminar      |      |         |                |               |    |       |   |   |   |   |   |
| Reception in Exhibit Hall              |      |         |                |               |    |       |   |   |   |   |   |



# Saturday, May 6

## SESSION V: 8:00 - 9:30 AM

- New Technologies Part I: Ultrafast CT & Cardiac Risk Reduction* – Louis E. Teichholtz, MD; *Telemedicine* – John A. Brennan, MD
- Ophthalmology for the Nonophthalmologist* – Anthony R. Caputo, MD
- Herbal Medicine Interactions with Anesthesia* – John B. Neeld, Jr, MD, Immediate Past-President, ASA
- Update in Pediatric Cardiology, Life Without Four Chambers: From Fetus Through Adulthood—A Team Approach* – Moderator, Milton Prystowsky, MD; Co-Speakers: Judith A. Becker, MD; William M. DeCampi, MD; Frederick K. Emge, MD; Shari Fallet, DO; Mark Farin, MD; Alan M. Langsner, MD; Pui-Kan Liao, MD; Brian K. O'Connor, MD; Anthony F. Rossi, MD; Rajiv Verma, MD
- Treating the Gay, Lesbian, Bisexual, and Transgendered* – Thomas S. Ziering, MD
- Association of BV & HIV* – Hugh W. Randall, Jr, MD
- Alzheimer's Disease: Slow but Steady Progress* – Norman H. Ertel, MD
- Why We Get Sick: The New Science of Darwinian Medicine and Psychiatry* – Randolph M. Nesse, MD
- Treating Respiratory Infections in the Age of Resistance* – John W. Sensakovic, MD, PhD, President, AMNJ
- Prenatal Testing for Endocrine Disorders* – Louis C. Haenel, DO
- State of the State in Cardiac Surgery* – Alan J. Spotnitz, MD
- Urinary Incontinence* – Rodney A. Appell, MD

## SESSION VI: 9:30 - 11:00 AM

- New Technologies Part II – Imaging Technology – The Critical Role of Positron Emission Tomography (PET) in Modern Oncology*, Abass Alavi, MD; *Laser Refractive Surgery* – James G. Nachbar, MD; *Chest CT for Smokers* – Judith K. Amorosa, MD & Mark Paul Bramwit, MD
- Sexual Harassment in the Workplace: The Trial of a Sexual Harassment Case* – Edward Ellis, Esq. & Donna M. O'Brien, Esq., Montgomery, McCracken, Walker & Rhoads, LLP

- Pediatric Myths, Misnomers, and Controversies* – Michael J. Gerardi, MD & Alfred D. Sacchetti, MD
- Epilepsy: New Medications and Surgical Techniques* – David M. Treiman, MD
- 35 Ways to Improve Your Office Efficiency Right Now* – Joseph S. Eastern, MD
- New Jersey Association of Ambulatory Surgical Centers* – TBD
- Primary Management of Ocular Emergencies* – Marta O. Lopatynsky, MD
- PM&R Billing & Coding* – Elaine Caruso-Gravatt, CMRA
- Advances in Spinal Surgery: New Treatment Methods for Osteoporotic Compression Fractures* – Kenneth J. Kopacz, MD; *Artificial Disc Replacements* – Casey K. Lee, MD; *Laser Discectomy* – Marc I. Malberg, MD
- Hospitalist: More Efficient Patient Care or the End of the Physician-Patient Relationship* – PRO and CON Debate – John R. Nelson, MD & Lanny Copeland, MD
- Urinary Incontinence* – Jerry G. Blaivas, MD

## PHYSICIANS-IN-TRAINING

- Procedures for Physicians-in-Training* – TBD
- The Next Step – Job Search* – TBD

# PLENARY SESSION

11:00 AM – 12:30 PM

KEYNOTE: RICHARD PRESTON, PhD  
"The Cobra Event:  
On the Trail of Biological Terrorism"

# Saturday, May 6

|                                                   | 7 AM | 8                                | 9             | 10 | 11 | 12 PM | 1 | 2 | 3 | 4 | 5 |
|---------------------------------------------------|------|----------------------------------|---------------|----|----|-------|---|---|---|---|---|
| MSNJ House of Delegates                           |      |                                  | Third Session |    |    |       |   |   |   |   |   |
| Exhibit Hall & Registration Open                  |      | Exhibit Hall & Registration Open |               |    |    |       |   |   |   |   |   |
| Breakfast, Breaks, Lunch provided in Exhibit Hall |      |                                  |               |    |    |       |   |   |   |   |   |
| Workshop Session 5                                |      |                                  |               |    |    |       |   |   |   |   |   |
| Workshop Session 6                                |      |                                  |               |    |    |       |   |   |   |   |   |
| Plenary Session: Richard Preston, PhD             |      |                                  |               |    |    |       |   |   |   |   |   |
| Physicians-in-Training Luncheon                   |      |                                  |               |    |    |       |   |   |   |   |   |
| Job Fair in Exhibit Hall                          |      |                                  |               |    |    |       |   |   |   |   |   |
| Workshop Session 7                                |      |                                  |               |    |    |       |   |   |   |   |   |
| Academy of Medicine of New Jersey Lecture         |      |                                  |               |    |    |       |   |   |   |   |   |
| MSNJ Presidential Gala (7:00 PM)                  |      |                                  |               |    |    |       |   |   |   |   |   |



# Sunday, May 7

## SESSION VII: 1:30 - 3:00 PM

- *New Developments in MR Angiography* – James P. Earls, MD
- *Complementary Medicine: Voodoo or Unrecognized Science* – Julius (Jay) A. Kaplan, MD
- *Physician on Trial* – Anthony Caggiano, MD & John J. Snyder, Esq., for Zurich Insurance
- *Update in the Diagnosis and Treatment of Prostate Cancer* – Louis Keeler, III, MD
- *Endoscopic Sinus Surgery from Anatomy to Ethmoidectomy to Advances in Frontal Sinus Surgery: 25 Years of Observation* – Steven D. Schaefer, MD
- *Clinical Update: Advances in the Diagnosis and Treatment of Osteoporosis* – Jeffrey P. Levine, MD
- *Genetics: A New Frontier* – Ronald J. Wapner, MD
- *Pediatric Dermatology* – Bernard A. Cohen, MD
- *Current Trends in Organ Donation and Transplantation* – Michael E. Shapiro, MD
- *Headache: Diagnosis and Treatment* – Loretta Mueller, DO
- *Staying Alive with Tachycardia* – Steven L. Winters, MD
- *Documentation Guidelines for PM&R* – Antoinette (Toni) M. Revel, RN, NP, CPC
- *New Approaches to the Management of Adult and Pediatric Patients with Attention Deficit Disorder* – Robert L. Hendren, DO

### PHYSICIANS-IN-TRAINING

- *Musculoskeletal Exams and Joint Aspiration* – TBD
- *Health Informatics* – TBD
- **Academy of Medicine of New Jersey Lecture**  
Christine M. Grant, JD, MBA, Commissioner,  
NJ Department of Health and Senior Services

## SESSION VIII: 9:00 - 10:30 AM

- *Using SNOMED RT in the Electronic Medical Record: Practical Comprehensive Coding for Reporting and Practice Management* – Chris Van Vleet, MS, Ed
- *Addiction Medicine* – Louis Baxter, MD, MSNJ Physician's Health Program
- *Negotiating with Managed Care* – Katherine Benesch, Esq., Archer & Greiner
- *Depression & General Anxiety in Women/Postpartum Depression and Women's Wellness* – Peter H. Silverstone, MD & Hilda B. Templeton, MD
- *Adult and Pediatric Immunization: What's New?* – William Atkinson, MD, MPH, Medical Epidemiologist, CDC
- *Clinical Trials: Where Does NJ Stand in the National Health Care Quality Improvement Clinical Priority Topic Areas* – Joseph A. Lieberman, III, MD, MPH; Vincent T. McDermott, Jr, MD; Edward Josell, DO; PRO of New Jersey, Inc.
- *Fraud and Abuse* – Patricia Costante & Lisa Kramer – MIIX Group of Companies
- *New Advances in Bloodless Medicine & Surgery* – Aryeh Shander, MD
- *Cancer Genetics Education for Health Care Professionals* – Deborah Lynn Toppmeyer, MD
- *Black Infant Mortality* – Unjeria C. Jackson, MD

## PLENARY SESSION

10:30 - 11:30 AM

**KEYNOTE: REP. GREG GANSKE, MD (Iowa),  
Managed Care Reform in Congress**

# Sunday, May 7

|                                          | 7 AM | 8             | 9 | 10 | 11 | 12 PM | 1 | 2 | 3 | 4 | 5 |
|------------------------------------------|------|---------------|---|----|----|-------|---|---|---|---|---|
| Exhibits Open                            |      | Exhibits Open |   |    |    |       |   |   |   |   |   |
| Continental Breakfast and Break          |      |               |   |    |    |       |   |   |   |   |   |
| Workshop Session 8                       |      |               |   |    |    |       |   |   |   |   |   |
| Plenary Session: US Rep. Greg Ganske, MD |      |               |   |    |    |       |   |   |   |   |   |

The Physicians Conference reserves the right to make program changes without prior notification. Check the MSNJ Web site, [www.msnj.org](http://www.msnj.org), for programming updates. No refunds will be given due to these changes.

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### **Congressman Greg Ganske, MD (R-IA)**

*Physician Advocate for Managed Care Reform in Congress*

Sunday, May 7: 10:30 AM - 11:30 AM (Closing Session)

As a physician member of Congress, Rep. Greg Ganske shares the frustrations within the health care community—and is working to bring about changes. Ganske cosponsors the Norwood-Dingell Patients' Bill of Rights and the Campbell Antitrust bill, two key pieces of health care legislation.

In his third term, Ganske sits on the critical House Commerce Committee, which handles more than 40% of all legislation. As the Physicians Conference closing speaker, he will provide keen insight to the Washington inner workings and the steps that physicians must take to achieve much-desired change.

Ganske completed his reconstructive surgery residency in 1984 at Harvard University, where he trained under Nobel Laureate Joe Murray. A lieutenant colonel in the US Army Reserves Medical Corps, Ganske had also operated a solo practice as a plastic and reconstructive surgeon in Des Moines for 10 years.

### **Physicians Public Affairs Seminar**

New Jersey Senate Health Committee Hearing

Friday, May 5: 3:30 PM - 5:00 PM

Physicians should seize this unique opportunity to testify before the NJ Senate Health Committee on the **State Action Doctrine**—one of the most important pieces of state legislation in years. Supported by Senate President Donald DiFrancesco, the State Action Doctrine would sidestep antitrust laws and allow independent physicians to negotiate with managed care companies on several key issues, including fees.

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\*Written verification required by Program Director Affiliation Practice Name School Name

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## Preregistration Summary

|                                  |          |
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| Physicians .....                 | \$199.00 |
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**Social Activities:**

|                                             |              |
|---------------------------------------------|--------------|
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| (Black Tie Affair - Open to all Attendees)  |              |
| A Day in Cape May.....                      | 52.00/person |
| Boardwalk 5K Fun Run/2K Fitness Walk... ..  | 25.00/person |

**Specialty Events:**

|                                                 |              |
|-------------------------------------------------|--------------|
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| MSNJA President's Luncheon (Fri., 5/5/00). .... | 35.00/person |
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|                                          |  |
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# PHYSICIANS CONFERENCE 2000

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This listing is for information only and does not imply Physician Conference endorsement. The rates listed are subject to a maximum of 12% room tax and a tourism promotion fee (\$2 per night for casino hotel rooms and \$1 per night for noncasino hotel rooms) for each occupied room.

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# New Jersey Prepares for a Possible Return of West Nile Virus

*An Interview with Eddy Bresnitz, MD, Assistant Commissioner/  
State Epidemiologist, and James Blumenstock, Senior Assistant  
Commissioner, Public Health Protection and Prevention  
Programs, of the NJ Department of Health and Senior Services*

**I**n the fall of 1999, West Nile virus became a household term especially in the tristate area of New York, New Jersey, and Connecticut. Before this epidemic of encephalitis was over, 61 cases were identified, seven of whom died. All cases were residents of New York City or surrounding state counties or had visited the city around the time of the epidemic. New Jersey residents were likely protected because of the long-standing mosquito control activities kept in place by state and county agencies.

New Jersey Medicine Associate Editor Leah Z. Ziskin, MD and Editor-in-Chief Paul J. Hirsch, MD, asked Dr. Eddy Bresnitz and Mr. James Blumenstock to review their experience during the 1999 epidemic and to tell us how the state of New Jersey is preparing for 2000.

**NJM:** Can you tell our readers how West Nile virus (WNV) entered the United States?

**Dr. Bresnitz:** We don't know when or how WNV entered the country. Several theories have been proposed. The most likely scenario is that illegally imported birds, which would

not have been quarantined or checked for illness, were infected. Other possibilities are that infected mosquitoes were imported or infected birds migrated to the United States.

The West Nile virus is classified as an arthropod-borne virus (arbovirus), and a member of the Japanese encephalitis antigenic complex of the genus *Flavivirus*. This complex includes the closely related St. Louis encephalitis, Japanese encephalitis, Kunjin, and Murray Valley encephalitis viruses, as well as others.<sup>1</sup> WNV was first isolated in the West Nile province of Uganda in 1937, and the first recorded epidemics occurred in Israel during the 1950s. Recent epidemics occurred in southeastern Romania in 1996 and in south-central Russia in 1999.<sup>2</sup> As you may recall, early reports from New York City were that the epidemic was thought to be St. Louis encephalitis, because the antibodies developed in WNV infection cross-react with those of the St. Louis virus.

**NJM:** Will the virus recur in the spring of 2000?

**Dr. Bresnitz:** We don't know—we have no idea whether the virus is going to be here in the spring. There are several unknowns, including whether the virus will stay alive in the mosquito larvae. We don't know if infected birds that survived are going to bring back the viruses from the south when they migrate north. Frankly, we just don't know enough about the life cycle of the virus and what its natural history will be in the coming season. We will be working with the Centers for Disease Control and Prevention (CDC) to determine these factors and also to set up surveillance systems.

**NJM:** How will you know if human cases occur?

**Dr. Bresnitz:** The network of infection control practitioners (ICPs) in NJ hospitals is essential to our effort. These practitioners are alert to cases that should be reported to the Department of Health and Senior



Services (DHSS) and to seek consultation on what specimens need to be submitted to the state laboratory to aid in the diagnosis. We have developed surveillance criteria for diagnostic testing of suspect cases of West Nile virus infection in New Jersey. [See Table 1.] Above all else, if a clinician suspects a case, it should be reported immediately to the DHSS and a call should be made before sending out specimens.

We discovered that last fall some physicians called CDC directly. This is not the most efficient or best way to get help, because CDC works through state health departments. The DHSS periodically sends reports to CDC, and during the epidemic we were in daily contact. In preparation for a recurrence of WNV, CDC will be training state laboratory personnel on the proper serology and viral isolation techniques. It is unlikely that commercial labs will be able to make the diagnosis as rapidly or accurately as the state laboratory. Physicians should be aware that reporting requirements will be in place for presumed and confirmed cases of viral encephalitis. Hospitals and laboratories are also required to report cases that come to their attention.

In summary, it will be most helpful to patients, clinicians, and our own efforts at tracking and controlling any outbreak or epidemic to have ICPs and physicians report to the DHSS at (609) 588-7500 or (609) 392-2020 before sending specimens to the state lab.

*Mosquitoes become infected when they feed on infected birds. After an incubation period of 10 to 14 days, infected mosquitoes can transmit WNV to animals and humans.*



*The incubation period in humans is usually 5 to 15 days. Case fatality rates range from 3% to 15% and are highest in the elderly.*

**SOURCE:** Centers for Disease Control and Prevention

Figure 1. West Nile Virus Transmission Cycle

**NJM:** Are there any antiviral therapies effective for WNV?

**Dr. Bresnitz:** To date, none of the available antiviral agents are effective against arboviruses, including WNV. Research is needed to find an effective medication. This also means that surveillance and prevention are exceedingly important and the primary tools for reducing morbidity and mortality.

**NJM:** What was the human experience in New Jersey in 1999?

**Dr. Bresnitz:** I am pleased to tell you that although specimens were

taken from about 50 individuals, no cases of WNV were identified in New Jersey residents, and I don't think this was only by chance.

For decades, New Jersey has had a state mosquito control commission and county mosquito control commissions and programs in place, and these agencies have maintained activities that prevent the proliferation of mosquitoes, the vector for WNV. This is not to say that the virus was not present in New Jersey in 1999. We know that the virus was found in two pools of mosquitoes

To identify human illness caused by West Nile virus (WNV) in New Jersey, New Jersey physicians are asked to report immediately to the New Jersey Department of Health and Senior Services (DHSS) by telephone [(609) 588-7500] any patients with the following syndromes:

1. Any adult or pediatric patient with the clinical syndrome that characterized most of the cases of encephalitis in 1999:

- a. Fever equal to or greater than 30° C or 100° F.
- b. Altered mental status (altered level of consciousness, lethargy, or change in personality).
- c. CSF pleocytosis with predominant lymphocytes and moderately elevated protein.
- d. Muscle weakness (especially flaccid paralysis) confirmed by neurologic exam or EMG

or

2. Any adult or pediatric patient admitted to the hospital with a presumptive diagnosis of viral encephalitis,

or

3. Any adult or pediatric patient admitted with presumed Guillain-Barre Syndrome or acute flaccid paralysis,

or

4. Any adult or pediatric patient admitted with presumptive aseptic meningitis (fever, headache, stiff neck, and/or other meningeal signs with CSF pleocytosis with predominant lymphocytes and moderately elevated protein, and a negative gram stain and culture to date) in counties with confirmed West Nile virus activity (i.e., human, avian, or equine cases; positive mosquitoes).

The DHSS will perform WNV testing on submitted specimens that meet the above criteria. In cases that have a low probability for WNV (e.g., only one or two of the four criteria in section 1, above) or if WNV activity has not been confirmed in the area of question, the physician can perform preliminary screening by testing a blood specimen for St. Louis encephalitis (SLE). Since SLE and WNV are closely related viruses, a WNV-infected patient will react positively to an SLE test. The DHSS should be notified of any positive SLE tests in these cases, so that follow-up testing for WNV can be performed.

In addition to the above passive surveillance, active surveillance will be carried out in the counties nearest to the Meadowlands (Bergen, Passaic, Essex, Hudson, and Union). Infection control professionals in all hospitals in these counties will be called once per week to ascertain whether any patients that meet the above suspect case criteria have been admitted to their hospitals.

from Hudson County. Birds have been the reservoir for arthropod viruses, and WNV is no exception. [See Figure 1.] The virus was found in birds from 16 NJ counties, including Atlantic, Bergen, Burlington, Cumberland, Essex, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Union, and Warren.

**NJM:** What types of surveillance systems need to be ready for 2000?

**Mr. Blumenstock:** To prepare for this type of disease, we need to enhance human, animal, and avian surveillance and to test mosquitoes and their larvae. We are working with local health departments and the NJ Department of Environmental Protection, the NJ Department of Agriculture, county mosquito control programs, and Rutgers University to set up animal and avian surveillance systems. As you recall, birds, especially crows, were found to be infected with WNV in most NJ counties. Crows appear to be susceptible to WNV and can alert us that the virus is in the vicinity. By selectively trapping birds and sampling mosquito pools, an active surveillance system can be established. If infection is located through any of the surveillance systems, additional measures can supplement ongoing mosquito control activities.

One issue that arose during the New York epidemic of 1999 is that of mosquito control and the application of pesticides. By having sur-

Table 1. Surveillance Criteria for Diagnostic Testing of Suspect Cases of West Nile Virus Infection in New Jersey



veillance systems in place, the need for emergency spraying programs and crisis management of the epidemic can be lessened. The concerns of environmentalists can be addressed and balanced with what we need to do to protect the residents living in areas at risk.

Helpful measures in addition to pesticides to control epidemics of arboviruses include land management to avoid water collections where mosquitoes breed and also biologic measures, such as stocking waterways with mosquito-larvae-eating fish.

During mosquito season, individuals should take precautions by wearing clothing that protects them from being bitten and using insect repellents containing DEET in accordance with label instructions. Special care should be taken by susceptible populations, especially the elderly.

**NJM:** Thank you, Dr. Bresnitz and Mr. Blumenstock, for sharing this information with our readers. 

## References

1. Chin J. Arthropod-borne viral diseases. *Control of Communicable Diseases Manual*. Washington DC: American Public Health Association. 2000; 17:28-54.
2. Hubalek Z, Halouzka J. West Nile Fever—a reemerging mosquito-borne viral disease in Europe. *Emerging Infectious Diseases*. September-October 1999;(5), 5.

## West Nile Virus The Need for Information

*Rita Manno, Director of Communications,  
New Jersey Department of Health and Senior Services*

West Nile virus has an exotic name. It's never been seen before in this country. And its carrier is a mosquito, a small creature usually considered annoying, not deadly.

But all of a sudden last summer, people were becoming infected with the virus, getting sick and sometimes dying. It was happening in New York. Could it happen and was it happening in New Jersey?

At the New Jersey Department of Health and Senior Services (DHSS), we quickly found ourselves at the center of attention. Reporters wanted information, updates, action plans, medical data, lab reports, numbers, and expert commentary. We were often talking with reporters more used to writing about politics and policy than viruses.

Our responsibility was to provide accurate information and convey clear, direct messages to the public whose fears grew as the number of New York City deaths increased and the number of infected crows falling from the sky in New Jersey went from a few to double digits.

We repeated the same messages daily over and over again to some 24 reporters and more than 25 local, state, and national news organizations. We wanted the public to understand the disease, that vulnerable populations such as the elderly were at special risk, and that despite the publicity no human case of West Nile virus ever emerged in New Jersey.

As the West Nile virus became a daily story, we began to put out public health alerts, press releases, and statements on our Web site—[www.state.nj.us/health](http://www.state.nj.us/health)—which was updated daily. We talked to reporters at all hours, joined daily conference calls with all our partners at CDC and other states, and worked closely with the governor's office, the New Jersey Departments of Agriculture and Environmental Protection, and local health and mosquito control officials.

Through the state epidemiologist, the department issued guidelines to medical professionals to determine whether patients' blood samples should be sent to the department for testing. "It was extremely important then and now to be in close contact with our physician community, so that we are able to track the disease and develop a plan of action," says DHSS Commissioner Christine Grant.

For weeks last fall, most media reported the facts and were careful not to create a climate of panic. Most media relied on experts. Still, there were misrepresentations. One reporter used the mother of a severely ill man from Lakewood as a medical expert with a medical diagnosis. Days later that diagnosis of West Nile infection proved to be wrong.

In more than one case, errors in a television story forced us into contacting scores of reporters to make sure the error wasn't repeated. One twist of a fact in a print story could set off a stampede by other reporters anxious to match what looked like new information.

As we approach the mosquito season and the possibility that West Nile virus might reappear, the need to convey clear, accurate information is more critical than ever.

We will use our Web site to post the most current information and link our site to others in the state, including the Medical Society of New Jersey. We're committed to giving the health care community, the media, and the public all the information they need. We take that responsibility seriously.



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<sup>1</sup>Underwriting approval required. <sup>2</sup>May need groups of 3 or more depending on speciality.

# DISABILITY AWARENESS: A CHECKLIST FOR THE MEDICAL PRACTICE

ALTHOUGH CONGRESS PASSED THE AMERICANS WITH DISABILITIES ACT (ADA) OF 1990, OUR NATION'S 54 MILLION PEOPLE WITH DISABILITIES CONTINUE TO FACE MANY CHALLENGES WHEN SEEKING HEALTH CARE. PHYSICIANS AND THEIR STAFFS CAN HEIGHTEN THEIR AWARENESS AND SENSITIVITY TO DISABILITY AND PROVIDE BETTER COMMUNICATION PLUS AN ORGANIZED SYSTEM OF CARE FOR PATIENTS WITH DISABILITIES.

*Roger I. Ceilley, MD; Stuart A. Hirsch, MD; Sandra Gordon, MA; Rebecca Gordon, BS*

Developing an awareness of how special populations differ from the general population and breaking down barriers for providing care creates a positive health care environment. This article provides an accessibility checklist, discusses some ADA requirements and common courtesies, and offers disability awareness guidance for developing a natural and comfortable approach for both physician and patients.

More than 54 million people in our nation have disabilities that interfere with obtaining access and acceptance in their communities.<sup>1</sup>

These disabilities include but are not limited to amputations, quadriplegia, hemiplegia, paraplegia, cerebral palsy, multiple sclerosis, muscular dystrophy, congenital disorders, blindness and partial sight, deafness and partial hearing loss, communication disorders, developmental disabilities, mental retardation, mental illness, and learning disabilities.

People with disabilities constitute one of the largest, fastest-growing minorities in the United States, increasing from 11.7% of the general population in 1970 to 20.6% in 1994.<sup>1,2</sup> As individuals, these wo-

men, men, and children are as different as the illnesses, birth conditions, accidents, or other factors that caused their disabilities.

A Louis Harris poll found that more than half of Americans feel awkward and embarrassed around a person with a disability.<sup>3</sup> Included in that 50% are physicians, nurses, and medical office staffs.

Persons with disabilities face a significant number of impediments when trying to obtain adequate health care. This is true despite the requirements of the Americans with Disabilities Act of 1990 (Public Law 101-336) passed by Congress and



signed into law on July 26, 1990.<sup>4</sup> Some of these impediments include:

- Physical access to physicians' offices (e.g., lack of ramps, parking for handicapped).
- Inadequate time. Physician work schedules that allow 15 to 20 minutes or less for each patient make it difficult to see some patients with disabilities who need more time for examinations, care, or treatment.
- Inadequate physician experience. Many physicians have had little experience or education in treating patients with disabilities. Without experience or education, physicians and other health care workers are uncomfortable with or unsure of how to care for disabled patients.

Gerber DeJong, PhD, director of the National Rehabilitation Hospital Research Center in Washington DC points out that "people with disabilities are high users of health care services. Within the working population, the 14% who have disabilities account for 64% of all health care expenditures for that age group."<sup>5</sup> Furthermore, Dr. DeJong states, "We still do not have good organized systems of health care for individuals with disabilities, particularly those with significant mobility impair-

ments."<sup>5</sup> DeJong describes six general ways in which the ongoing health care needs of people with disabilities differ from those of the general population:

- People with disabilities generally have a *thinner margin of health* that must be carefully guarded if medical problems are to be averted.<sup>6</sup> Impairments and functional limitations make them more vulnerable to certain health problems.
- People with disabilities often do not have the same opportunities for *health maintenance and preventive health* as those without disabilities. For example, people with mobility limitations have fewer opportunities for the aerobic activity needed for good cardiovascular health.
- They may experience an *earlier onset of chronic health conditions*, especially if they acquire their impairments early in life (e.g., earlier onset of cardiovascular disease secondary to inactivity; adult onset diabetes secondary to obesity; and renal disease, such as pyelonephritis secondary to neurogenic bladder).
- They may have *greater susceptibility to secondary functional losses*. The functional consequences of the new chronic health condition are usually greater.

- There may be a *more complicated and prolonged treatment* for a given health problem (e.g., inability to participate in exercise therapy after an acute myocardial infarction).
- The *need for durable medical equipment and other assistive techniques* that require some level of functional assessment.

A recent issue of *Technologica* described three valuable ways to break down the barriers to caring for people with disabilities:<sup>7</sup>

- First, use patient advocacy to help physicians understand and address the needs of special populations.
- Second, intervene early in medical school training to educate about the care of people with disabilities.
- Third, develop programs that provide a continuum of health care services for people with disabilities by partnering the medical and social needs of these patients.

Training in medical school generally lacks any curricular component related to the care of people with disabilities. Carol J. Gill, PhD, assistant professor of human development at the University of Illinois at Chicago, said, "Physicians and other health care professionals are

not being taught that disabled people will be part of their practices; rather, they believe that the disabled are being shunted off to someone else's specialty. Young physicians often feel that they will not necessarily encounter patients with disabilities in their practices."<sup>8</sup>

Dr. Gill points out that "disability includes not just the physical stuff you can see—a wheelchair or a pair of crutches—but includes everything from learning disabilities to psychiatric disabilities and sensory disabilities. In fact, the Americans with Disabilities Act defines 'disability' as having a limitation in one or more major life activities, or being regarded as having such a limitation, or having a record of having such a limitation."<sup>4</sup>

In 1988 the American Medical Association, in cooperation with the American Academy of Physical Medicine and Rehabilitation, developed a manual that explains the ADA and how it affects the practice of medicine.<sup>4</sup>

As our population grows and ages, an increasing number of patients will use wheelchairs or develop vision or hearing impairments. Making changes in physician offices to accommodate these patients is not just the law; it is good business and compassionate patient care.

Physical changes alone will not remove the barriers. It is important that physicians and other health care workers avoid negative behavior and put into practice basic principles that will make the disabled person feel welcome and comfortable.

The checklist (see sidebar) can help to assess how welcoming a physician's office is. In addition, the following are general considerations of disability etiquette:

- Treat people with disabilities with the same courtesies as others are treated.
- Treat adults as adults.
- When talking with someone who has a disability, speak directly to that person rather than through a companion who may be present.
- When greeting a person with a severe loss of vision, always identify yourself, and speak in a normal tone of voice.
- To get the attention of people with hearing disabilities, tap them on the shoulder or wave your hand.
- When talking with a person in a wheelchair for more than a few minutes, sit, if possible, so as to be at that person's eye level.

- Give a person who has difficulty speaking unhurried attention. When possible, questions should require short answers or merely a nod or shake of the head.

Additional information may be obtained from the organizations listed in Table I.

Patients with disabilities are an important part of the everyday population visiting doctors' offices. There have been legislative steps taken to ensure access to medical care, but laws do not create the attitudes that ensure equal access to health care. It is the personal obligation of caring physicians and their staff to meet the special requirements of this large group of patients. Many patients have described their disability as a source of strength. Physicians are at their best when they advocate for their patients. The medical community should commit to the goal of full and equal care of patients with disabilities. Meeting their patients' needs with sensitivity and quality is the benchmark of our finest physicians. The small costs in time and effort to achieve gains in access for patients will be matched by big gains



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President's Committee on  
Employment of People with  
Disabilities  
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Suite 300  
Washington DC 20004  
(202) 376-6200  
Fax: (202) 376-6219  
Web: [www50.pcepd.gov/pcepd](http://www50.pcepd.gov/pcepd)

Paralyzed Veterans of America  
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(800) 424-8200  
Web: [www.pva.org/index.htm](http://www.pva.org/index.htm)

Eastern Paralyzed Veterans  
Association  
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Jackson Heights NY 11370  
(718) 803-3782  
Fax: (718) 803-0414  
Web: [www.pva.org/chap/epva.htm](http://www.pva.org/chap/epva.htm)

Americans with Disabilities Act  
Accessibility Guidelines  
Web: [www.access-board.gov/bfdg/adaag.htm](http://www.access-board.gov/bfdg/adaag.htm)

American Council of the Blind  
1155 15th St. NW  
Suite 720  
Washington DC 20005  
(202) 467-5081  
Fax: (202) 467-5085  
Web: [www.acb.org](http://www.acb.org)

American Foundation for the Blind  
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(212) 502-7661  
Fax: (212) 502-7777  
Web: [www.afb.org](http://www.afb.org)

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in personal satisfaction for physicians.

Communicating with people with disabilities can be difficult. But, if words and actions show respect, if people are treated with dignity, the result will almost always be positive.

Charles Krauthammer wrote in a recent *Washington Post* editorial: "Disability—like exile, the human condition it most resembles—neither ennobles nor degrades. It frames experience. It does not define it."<sup>9</sup>

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Table 1. Organizations with Information on People with Disabilities

## ACCESSIBILITY CHECKLIST FOR THE MEDICAL OFFICE

- ☐ Designated handicapped parking spaces, marked by a sign, should be at least 96 inches wide, with 36 inch-wide access aisles.
- ☐ Curb ramps at least 36 inches wide should connect the parking area with an accessible route to the building.
- ☐ Entrances should be level or ramped, with a minimum slope and with easy-to-operate doors that are at least 36 inches wide.
- ☐ Aisles should be at least 36 inches wide.
- ☐ Signs should have raised letters, as well as messages in Braille.
- ☐ Emergency alarms should give both visible and audible warnings.
- ☐ Public restroom stall openings should be at least 36 inches wide, with doors that close behind a wheelchair. Toilets, bars, and accessories have specific required heights.
- ☐ Carpet or other flooring should not have a high pile or other feature that makes it difficult for a person who uses a wheelchair to get around.
- ☐ The entrance door handles should allow someone with limited hand use to open the door.
- ☐ The registration desk should allow someone in a wheelchair to be seen and sign in.
- ☐ Someone should be available to assist patients with limited vision, hand movement, mental retardation, or learning disabilities to fill out forms.
- ☐ A deaf or hearing-impaired patient should be able to call the office for an appointment.
- ☐ The office staff should be trained in disability etiquette.
- ☐ Public education materials and pamphlets should be available in large print.

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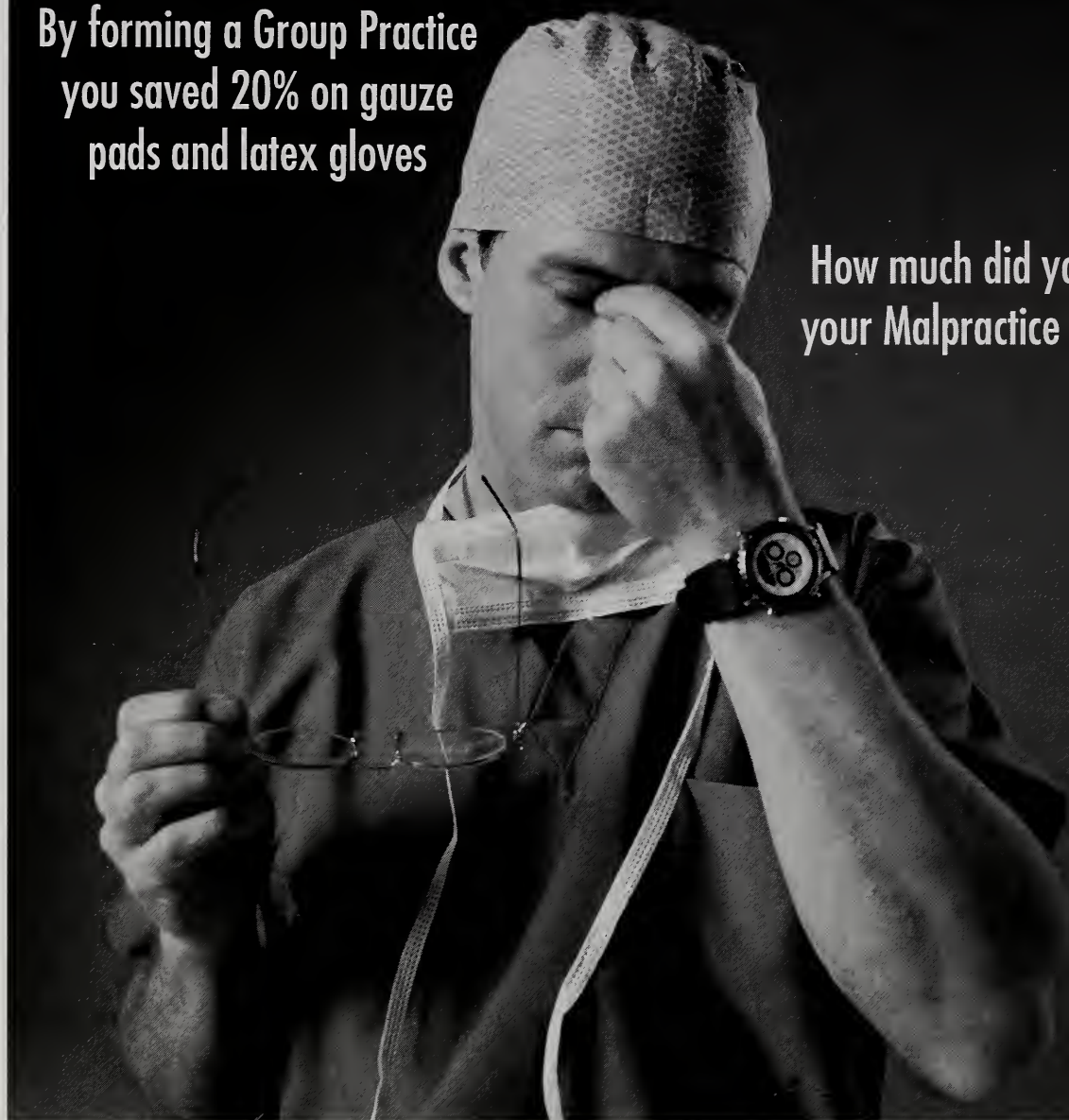
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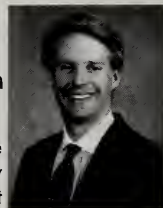
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# PRACTICE CONSOLIDATION AND RETIREMENT PLANS: FINANCIAL RAMIFICATIONS

*Paul G. Donnelly, CLU, ChFC; Gary Clancy, CFP*

**A**s we enter the 21st century, very little is taken for granted in the health care field, particularly the physician sector. If there is one common belief, however, it is that solo and small medical practices will continue to consolidate into single-specialty and multi-specialty groups. One important facet of physician consolidation—and the area most often overlooked in the decision process—is the impact on the physician's financial future.

The financial incentives of group formation can include:

- More bargaining power in negotiating managed care contracts.
- Increased purchasing power because of economies of scale.

- Enhanced access to capital for practice improvements and new equipment purchases.
- A steady and increased revenue stream.

## What are the Qualified Plan Issues of Consolidating Practices?

An area frequently overlooked in the practice-consolidation planning process is the impact on the existing qualified retirement plans from the solo practices. This area needs to be examined thoroughly when practices are consolidated. Decisions need to be made as to whether to merge the plans or terminate all previous plans and start over with a new one. The financial and legal ramifications of each potential decision must be carefully considered.

Qualified plans are governed in part by the Employee Retirement Income Security Act (ERISA) laws, which state that if a qualified retirement plan is terminated, all participants immediately become 100% vested in the plan, regardless of tenure. This allows the participants the benefit distribution election of either receiving a cash payment (taxes and perhaps a 10% penalty apply) or transferring their account balances to an IRA or a subsequent employer retirement plan if allowed.

Merging plans can allow the old vesting schedule to remain intact and combine the assets of the merged plans, but practices must use caution before performing a plan merger. If one or more of the plans has a problem, it can have a



negative impact on any subsequent plan. For example, let's assume that one of the plans being merged is top heavy and discriminates against non-highly compensated employees by not providing required qualified nonelective contributions (QNECs). This type of arrangement can disqualify the IRS tax status of the merged plan, possibly resulting in a taxable distribution of assets or a fine to the company or both.

If the decision is made to start a new plan, where does the practice begin? One of the first decisions that must be made is the type of retirement plan to adopt. There are many retirement plan types available to plan sponsors. Partners or owners need to decide whether they want a plan that enhances benefits for the owners or a more uniform plan design that can benefit employees. It is important that the plan meets the objectives of all partners or owners.

Setting up a plan also requires a plan adoption agreement or a custom plan document to be completed. Often a prototype plan document is suitable and less costly. Care needs to be taken in completing the plan document. Because the

completed plan document is binding, the group will have to live with it in the future unless it is amended. Issues such as vesting, eligibility, contribution and/or benefit formulas will be stated in this document.

The task of terminating, merging, or structuring a qualified plan can be daunting for even the most business-savvy physician. A mistake in the process, no matter how unintentional, can be potentially costly to the plan sponsor. Advice from a retirement plan specialist is recommended to guide the group through the legal and financial ramifications of qualified plan design.

### **What are the Risk Management Issues of Consolidating Practices?**

What happens when the revenue stream is interrupted due to a separation of service, disability, or death of one of the partners or practicing physicians? Will the practice be indemnified for any loss of income or the cost of hiring a replacement? In the event of retirement or separation of service, will funds be readily available to payout partners? Unless risk management is addressed upfront, the financial impact to the physicians and the practice can be overwhelming.

When group members all have a stake in the success and control of the practice, they also share in the financial risks and rewards of their efforts. After the formation of a group practice, one of the concerns should be to design a buyout plan for the owners. In doing so the following issues should be examined:

- What type of legal buyout agreement should be created? Should it be a cross-purchase or stock-redemption plan?
- What formula will be used to value the practice?
- Will a professional appraisal/valuation be provided?
- Who will buy the practice? Will it be an existing partner or will the practice need to find another potential buyer?

Many events can trigger a buyout—death, disability, retirement, or separation of service. Our experience shows that death is typically the only event considered; yet statistically it is one of the other events that will usually trigger a buyout.

*Paul G. Donnelly and Gary Clancy are partners in Healthcare Business Planning Group LLC, Edison NJ.*

# APPELLATE COURT UPHOLDS MIIX CONVERSION

ON FEBRUARY 14, 2000, THE APPELLATE DIVISION OF NEW JERSEY SUPERIOR COURT ISSUED AN EXTENSIVE OPINION THAT FIRMLY UPHELD MIIX'S CONVERSION FROM A RECIPROCAL TO A STOCK INSURANCE COMPANY. THE COURT RULED THAT THE MIIX PLAN OF REORGANIZATION, BY WHICH THE CONVERSION WAS ACCOMPLISHED, WAS CARRIED OUT STRICTLY IN ACCORDANCE WITH LAW AND THAT THE PLAN'S METHOD OF DISTRIBUTING STOCK IN THE NEW COMPANY TO MIIX'S MEMBERS WAS FAIR AND REASONABLE. THIS DECISION CONCLUSIVELY REJECTED THE CHALLENGE TO THE PLAN MADE BY THREE DISSIDENT MIIX MEMBER PHYSICIANS.

*David J. D'Aloia, Esq.*

**T**his is the end of a story that first began on October 15, 1997, when the MIIX board of governors approved the plan of reorganization. The plan was adopted after months of study by the MIIX board and management, review and recommendation by the company's investment bankers, financial analysts, attorneys, and accountants, and the painstaking drafting of the plan's provisions. The conversion itself was conceived to benefit both the company and its members. Once the conversion to a stock company was completed, MIIX could issue

publicly traded stock in an initial public offering (IPO) and obtain access to this critical financial market. For no payment whatsoever, members would receive valuable stock in the new company that could be bought or sold in the public stock market. The insurance-buying public would also be confident of a financially stable medical malpractice insurer that was committed to the New Jersey market for the long haul.

It was really a win-win situation for everyone. A small group of dissident MIIX member physicians, however, were intent on upsetting

the conversion out of a desire to obtain more MIIX stock for themselves to the detriment of other MIIX members.

## The Steps To Approval

Following the MIIX board's adoption of the plan, it was presented to the New Jersey Department of Banking and Insurance for regulatory approval. Written notice was sent to MIIX members that the department would hold a public hearing on the plan in the upcoming months. After careful review of the plan's provisions by department staff, a public hearing was scheduled for December 22, 1997. Notice of



the hearing date was then sent to all MIIX members.

MIIX management testified extensively at the hearing about the benefits of the plan, including the company's need for access to financial markets and the distribution of stock in the new company to MIIX members. Under the plan, stock was to be distributed to anyone who was a MIIX member during the three-year period before the plan adoption date of October 15, 1997, in proportion to the policy premiums they paid during that same period. Evidence was presented showing that this "look-back" approach to stock distribution was supported by the conversion statutes of other states across the country. The plan also provided that MIIX would acquire New Jersey Medical Underwriters, Inc., a company created by MSNJ in 1977 to manage MIIX's business, for \$11 million in stock and \$100,000 in cash. This valuation was supported by the fairness opinion and the valuation report of Solomon Brothers, MIIX's financial advisor in the conversion, and presented as evidence at the public hearing. No one appeared at the hearing in opposition to the plan.

After the hearing, Assistant Commissioner Donald Bryan, who

acted as the department's hearing officer, issued a comprehensive hearing report that endorsed the MIIX plan and recommended its approval by the commissioner. The report acknowledged the many benefits of the plan to the company, its members, and the public. Assistant Commissioner Bryan also found that the plan's method of stock distribution was "clearly reasonable and equitable" and that the valuation of Medical Underwriters was also reasonable and supported by the Solomon Brothers fairness opinion. The report noted that the conversion would be transparent to policyholders, essentially involving a change from one legal form (reciprocal) to another (stock company). On the basis of this report, the commissioner entered an order approving the MIIX plan of reorganization on March 5, 1998.

### The Roadblock

A law firm representing three MIIX member physicians then filed an application asking the commissioner to rescind her approval of the plan. They questioned whether the conversion was necessary and, in what was apparently their main concern, contended that as long-time MIIX members they should receive

more stock under the plan than other members. The commissioner denied the application in a detailed analysis that found that the conversion would financially strengthen MIIX, the stock distribution was fair and equitable, and the doctors had provided no valid reason why the company's future course should not be submitted to a vote of its members. On May 8, 1998, the three doctors appealed the commissioner's order to the courts. MSNJ intervened as a party in the appeal to protect its own interests.

These doctors and their law firm then engaged in every legal maneuver imaginable to prevent the conversion from taking place, in a campaign that was apparently designed to force MIIX either to change the plan's stock distribution to give them preferential treatment or to negotiate a quick cash settlement. MIIX did neither, believing instead that it was essential for the plan to treat all members equally rather than preferring one special interest group over other members.

The three dissident doctors and their law firm first moved to prevent the plan from being completed until the appeal of the commissioner's order was decided. The court, however, refused to stay the completion

of the plan, finding that the doctors had not shown a "probability of success" on their arguments, the legal standard by which such a stay application is judged. The law firm then filed a separate proposed class action suit against the company and its management, again contending that the plaintiff doctors should receive a disproportionate share of the stock in the new company. As the members' vote on the plan approached, the doctors' law firm filed not one, but a series of seven separate applications in the class action suit or the appeal proceeding to stop the plan, the members' vote on the plan, or the IPO from being completed.

Each and every one of these injunction and stay applications was denied by the courts, including the Chancery Court, the Superior Court, Appellate Division, and the New Jersey Supreme Court, based, once again, on the finding that there was no probability of success to the arguments advanced by the plaintiffs. In addition, the chancery court dismissed the entire proposed class action suit, ruling that there was absolutely no legal basis on which the plaintiff doctors could maintain their suit against the company. The doctors' attempt to convert the appeal of the commissioner's order

into a class action was also denied by the court.

### The Outcome

With all of these legal obstacles thrown up by the dissident doctors rejected, the MIIX plan of reorganization was finally put to a vote by MIIX members. On March 17, 1999, the plan was approved by an overwhelming vote of 92.6% of the voting members. The initial public offering of the company's stock then took place in July 1999. At that time, MIIX members received their distribution of stock in the new company as provided by the MIIX plan.

In November 1999, a panel of three appellate judges heard oral argument on the three doctors' appeal of the commissioner's order approving the MIIX plan. For more than two hours, this panel of respected judges heard point and counterpoint on the legal validity of the plan and its method of stock distribution to members, as well as the doctors' arguments in favor of a larger stock distribution to long-time members.

The appellate court's recently issued opinion finally decides those issues. The court found, first, that the commissioner acted well within her statutory authority in approving the MIIX plan and that it was for-

mulated in accordance with law. Significantly, the court also ruled that the plan's three-year look-back approach to stock distribution was reasonable and in accordance with analogous laws throughout the country, based on a detailed and extensive review of the laws of 25 states with conversion statutes. Finally, the court held that the consideration paid by MIIX to acquire Medical Underwriters was fully supported by the evidence presented.

In sum, both the commissioner and the courts of this state have repeatedly endorsed the validity of the MIIX conversion and the propriety of the distribution of the new company's stock to MIIX members. Without exception, they have found that the plan and its method of stock distribution are legally valid, fair, and reasonable. While the dissident doctors may be disappointed that they did not receive a disproportionately larger share of MIIX stock for themselves, the conclusion of the commissioner and the courts is certainly the right one.

*David J. D'Aloia is a member of the law firm of Saiber Schlesinger Satz & Goldstein, LLC and represented the Medical Society of New Jersey in the appeal of the New Jersey Insurance Commissioner's approval of the MIIX plan of reorganization.*





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This site provides information related to clinical trials, such as a listing of more than 41,000 industry- and government-sponsored clinical trials as well as new drug therapies recently approved by the FDA.

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As of March, the MSNJ Web site, [www.msnj.org](http://www.msnj.org), was completely revamped and redesigned to enhance user friendliness and increase the ease of finding information. The site now offers a search engine and map to help find information quickly. The public side of the site is immediately accessible through the buttons on the home page, while members can easily click through to the members-only area. The popular Physician Finder is also featured prominently on the home page.

Among other enhancements, the site has considerably expanded its coverage of the Physicians Conference 2000, with registration and hotel information in downloadable form. In the Member Services area, there is a section devoted to practice management. The members-only welcome page also features an interactive member survey, allowing the society to poll its members on various topics of interest or contention.

Some areas continue to be under construction, and the Web site will continue to evolve in response to members' suggestions, which we welcome receiving at [info@msnj.org](mailto:info@msnj.org).

### MEDICAL DIRECTORY LISTS

#### PRODUCTS, SERVICES

A new medical site, [www.medcatalog.com](http://www.medcatalog.com), provides information on medical books, products, manufacturers, and suppliers. It offers links to all medical company sites and allows users to request information directly from manufacturers. In addition, there is a section on preowned equipment for sale. The site offers daily updated health information and provides links to medical information sites as well as to recruitment sites.

#### MEDICAL MONITORING

InforMedix, Inc. offers the Med-eMonitor System, which is designed to improve the medication compliance and health status of anyone taking medications. The system allows pharmaceutical companies, HMOs, managed care organizations, clinical research organizations, home health companies, health care providers, and others to monitor patient safety, medication compliance, and health status. The portable, patient-based Internet and telemedicine health care technologies monitor medication compliance and electronically link patients and health care professionals to improve health outcomes and reduce health care costs.



for multiple diseases. The Web site is [www.informedix.com](http://www.informedix.com).

Infu-Tech, Inc., a pharmaceutical provider, through its Smartmeds.com unit ([www.smartmeds.com](http://www.smartmeds.com)), and Infospace.com, a provider of infrastructure services for wireless devices, merchants, and Web sites, announced that they will work jointly to develop a platform for wireless interactive

health care communications to assist in disease state management and business-to-business health commerce. The platform will incorporate Internet and wireless communications technologies to integrate personalized medical content, commerce, and disease management services. It initially will perform a variety of tasks central to notifying and monitoring patients' drug compliance with the purposes

of enhancing patients' wellness and measuring clinical outcomes. The system will be able to notify patients of the proper times and dosage of medications. Patients will be able to upload vital clinical signs and medication compliance measures that could lead to interactive communication between physicians and managed care organizations to better monitor and manage patients' health needs.

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# CALENDAR

**E V E N T**

**D A T E**

**L O C A T I O N**

## A p r i l

|                                            |                   |                                                                               |
|--------------------------------------------|-------------------|-------------------------------------------------------------------------------|
| <b>Hepatitis</b>                           | April 12, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>American Surgical Association</b>       | April 13-15, 2000 | Philadelphia Marriott Hotel, (978) 526-8330                                   |
| <b>Nephrology Society Meeting</b>          | April 18, 2000    | UMDNJ-Robert Wood Johnson Medical School, New Brunswick, AMNJ, (609) 275-1911 |
| <b>Peripheral Vascular Disease</b>         | April 19, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Polymyalgia Rheumatica</b>              | April 26, 2000    | St. Mary's Hospital, Passaic, (609) 275-1911                                  |
| <b>AMA Intel Internet Health Road Show</b> | April 28, 2000    | Philadelphia Marriott Downtown, (909) 558-7252                                |

## M a y

|                                                                                                      |                 |                                                              |
|------------------------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------|
| <b>Cardiac MRI</b>                                                                                   | May 2, 2000     | Jersey Shore Medical Center, Neptune, (732) 776-4420         |
| <b>First Annual New Jersey Physicians Conference</b>                                                 | May 4-7, 2000   | Atlantic City Convention Center, MSNJ, (609) 896-1766        |
| <b>American Occupational Health Conference</b>                                                       | May 12-19, 2000 | Pennsylvania Convention Center, Philadelphia, (847) 818-1800 |
| <b>HIV 2000: The Battle Continues</b>                                                                | May 13, 2000    | UMDNJ, New Brunswick, (732) 235-7430                         |
| <b>2nd International Congress on Heart Disease: New Trends in Research, Diagnosis, and Treatment</b> | May 14-17, 2000 | Washington DC, (310) 657-8777                                |
| <b>Greater New York Physicians Expo</b>                                                              | May 16-17, 2000 | Javits Convention Center, New York NY, (212) 216-2000        |
| <b>Evaluation and Management of Syncope</b>                                                          | May 23, 2000    | Jersey Shore Medical Center, Neptune, (732) 776-4420         |
| <b>Digestive Disease Week</b>                                                                        | May 18-24, 2000 | Washington DC, (609) 848-1000                                |
| <b>AMNJ Annual Awards Dinner</b>                                                                     | May 24, 2000    | Chanticleer, Short Hills, AMNJ, (609) 275-1911               |

## J u n e

|                                                              |                |                                                      |
|--------------------------------------------------------------|----------------|------------------------------------------------------|
| <b>17th Symposium for Computer Applications in Radiology</b> | June 3-6, 2000 | Philadelphia Marriott Hotel, (703) 757-0054          |
| <b>Clinical Spectrum of Esophageal Mobility Disorders</b>    | June 6, 2000   | Jersey Shore Medical Center, Neptune, (732) 776-4420 |
| <b>Meningitis</b>                                            | June 7, 2000   | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911   |



# A L E N D A

**E V E N T**
**D A T E**
**L O C A T I O N**
**J u n e**

|                                                                                                            |                  |                                                                               |
|------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------|
| <b>Third International Conference on the Mechanisms and Treatment of Neuropathic Pain</b>                  | June 8-10, 2000  | Renaissance Hotel, Washington DC, (514) 286-0855                              |
| <b>Certified Coding Specialist—Physician-based Exam</b>                                                    | June 10, 2000    | American Health Information Management Association, (312) 233-1160            |
| <b>AMA Annual Meeting</b>                                                                                  | June 11-15, 2000 | Chicago Hilton & Towers, (312) 464-5000                                       |
| <b>Rheumatoid Arthritis: A New Look at an Old Disease</b>                                                  | June 14, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Nephrology Society Meeting</b>                                                                          | June 20, 2000    | UMDNJ-Robert Wood Johnson Medical School, New Brunswick, AMNJ, (609) 275-1911 |
| <b>New Anticoagulants—Promises and Problems</b>                                                            | June 20, 2000    | Jersey Shore Medical Center, Neptune, (432) 776-4420                          |
| <b>Tuberculosis 2000</b>                                                                                   | June 20-24, 2000 | The Roosevelt Hotel, New York NY, (202) 737-3600                              |
| <b>Chronic Pain Management</b>                                                                             | June 21, 2000    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Building Systems That Do No Harm: Advancing Patient Safety Through Partnership And Shared Knowledge</b> | June 28-30, 2000 | Dallas, (312) 543-5658                                                        |

**J u l y**

|                                                                                    |                        |                                         |
|------------------------------------------------------------------------------------|------------------------|-----------------------------------------|
| <b>International Conference on Alzheimer's and Related Disorders</b>               | July 9-14, 2000        | Washington DC, (312) 335-8700           |
| <b>13th International Symposium on Treatment of Leukemia, Lymphoma, and Cancer</b> | July 14-18, 2000       | New York NY, Imedex USA, (770) 751-7332 |
| <b>Update and Intensive Review in Internal Medicine</b>                            | July 30-August 5, 2000 | New York NY, (212) 781-5990             |

**S e p t e m b e r**

|                                                                          |                       |                                                                    |
|--------------------------------------------------------------------------|-----------------------|--------------------------------------------------------------------|
| <b>American Association of Electrodiagnostic Medicine Annual Meeting</b> | September 13-16, 2000 | Philadelphia Marriott, Philadelphia, (507) 288-0100                |
| <b>Certified Coding Specialist—Physician-based Exam</b>                  | September 16, 2000    | American Health Information Management Association, (312) 233-1160 |
| <b>American College of Radiology Annual Meeting</b>                      | September 23-27, 2000 | New York Hilton & Towers, New York NY, (703) 716-7545              |

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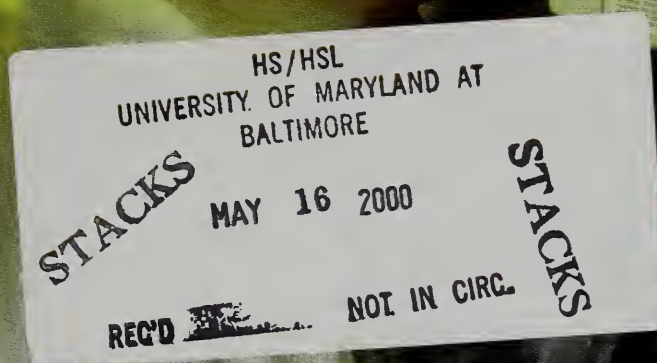


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## Doctors' role in the coup de tech

Can New Jersey physicians respond effectively to the Information Revolution?

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To employ historian John Lukacs's dichotomy, physicians' adaptation to the information environment reflects the "motive" of the "push of the past," while physicians' desire to stake out a leadership position reflects the "purpose" of the "pull of the future."

Consider the following reported developments to see whether you feel pushed or pulled.

**Clinical Communication.** Automation of clinical data is seen as a necessary first step in preventing medical errors at Intermountain Health Care in Salt Lake City, according to *Medicine & Health Perspectives*. Medication errors, falls,

nosocomial infections, and other persistent problems lend themselves to data-driven quality improvement campaigns. Intermountain vice-president Brent James, MD, told the newsletter, "Once we computerized our work, 80 times more true adverse drug events were found."

The *Healthcare Leadership Review* reports a series of findings on the medical relevance of Internet technology. Writes trend-spotter Russell C. Coile, Jr., "Internet technology may rank with antibiotics, genetics, and computers as among the most important changes for medical care delivery."

Can e-mail facilitate physician-patient communication? A Stanford University study, summarized in the review, showed that 46% of patients use e-mail, and just more than half of those would like to use it to communicate with health care providers. Interestingly, an Oklahoma-based study revealed an even higher proportion of patients interested in e-mail communication with physicians, more than 80%.

**Patients and Populations.** With Internet connectivity, physicians'

claim to expertise will evolve. Kent Bottles, MD, of Genomics Collaborative in Cambridge, Massachusetts, observes, "Anyone with a computer and a modem can access information that used to be the specialist's sole province." Showing that assessments of patients can occur outside physicians' offices or purview, a Japanese company is pioneering use of a "smart toilet" that analyzes

**A** decision in the Appellate Division of the Superior Court provides a glimpse into the likely effects of "affidavit of merit" legislation. Part of a package of reforms promoted by the Medical Society of New Jersey, the law requires would-be plaintiffs in malpractice suits to obtain an expert opinion. The court threw out a case when the plaintiff's expert was uncertified and failed to respond in the proper format within 60 days of the defense request.

patients' waste products and transmits the results. More information, however, doesn't necessarily mean better decisions, the review cautions.

Through the Internet, information can be concentrated for a specific patient. Stan Bernard, MD, MBA, in another commentary summarized in the review, offers the example of a newly diagnosed



diabetic patient. Dr. Bernard says the patient could obtain information about diabetes, order prescriptions electronically and receive instant adjudication of prescription claims through the patient's insurer, use blood glucose monitoring programs, schedule appointments with physicians and other providers, and set up customized reminders to boost compliance—all at a single site.

Even macro health care approaches are influenced by the Information Revolution. At nearby Jefferson Health System, evidence-based medicine has emerged as a controlling priority, as the Philadelphia system takes responsibility for population-based care.

Physicians recognize that information technologies allow electronic compilation and dissemination of physician profiles. In one approach, PacifiCare alerts its members to the performance of medical group practices, not individual physicians, in such indicators as breast cancer screening and patient satisfaction.

**Business of Medicine.** Blaine Bos of locally based Mercer/Foster Higgins, which conducts the national survey of employer-sponsored health plans, sees that preferred provider organizations

(PPOs) "have been quietly evolving into true managed care plans."

Marsha Gold of Mathematica Policy Research confirmed the trend, telling the Medicare Payment Advisory Commission that moving risk downstream is a common practice across the country. Eighty percent of health plans share risk. Many PPOs already pay hospitals on a per-diem or per-diagnosis (DRG) basis and use disease management.

The main differences between PPO and HMO practices, according to the *Medicine & Health Perspectives* article that quotes these researchers, is that PPOs don't follow the primary care gatekeeper model and conduct less prospective review. As a result, PPOs' administrative costs are below those of HMOs or point-of-service plans. The article comments that PPOs also are easy for employers to self-fund or customize.

Women get a lot of attention in health care marketing these days, but the untapped market may be male. A Commonwealth Fund study reported that 24% of men and only 8% of women said they hadn't seen a physician in more than 12 months. One-third of the men allowed they don't have a regular physician.

*Medicine & Health*, which is among the publications reporting the

news about doctorless males, further relates that enrollment in the new Medicare+Choice program actually may be decreasing. It started the year at 6.3 million.

**Government Responsiveness.** The chair of the Practicing Physician Advisory Council (PPAC), Marie G. Kuffner, MD, has had it. The UCLA anesthesiologist urges Health & Human Services secretary Donna E. Shalala, PhD, "to reexamine the commitment and direction your administration can and should take to improve the relationships between the Medicare program and the practicing physician community."

Dr. Kuffner notes that physicians lack faith in the system. She complains that the administration has given short shrift to PPAC's opinions.

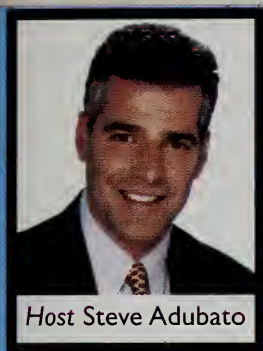
Health care employers don't work at training managers or promoting employee satisfaction, reports Jane Lowers in an article summarized in the *Healthcare Leadership Review*. Poor communication with employees appears widespread.

New Jersey patients and the health care field have lost an important regulator. Assistant Commissioner of Banking & Insurance Paul L. DeAngelo died suddenly April 5 at age 46. Mr. DeAngelo supervised the handling of complaints against carriers. ■



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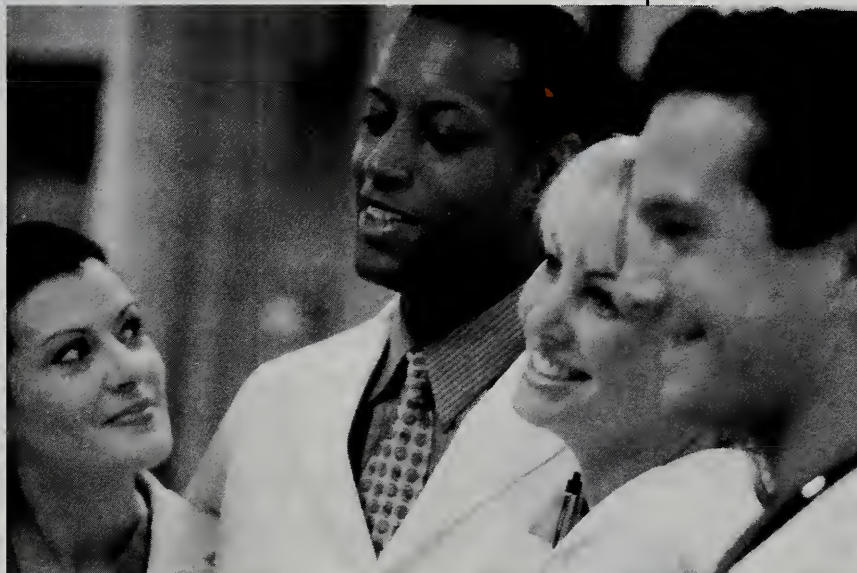
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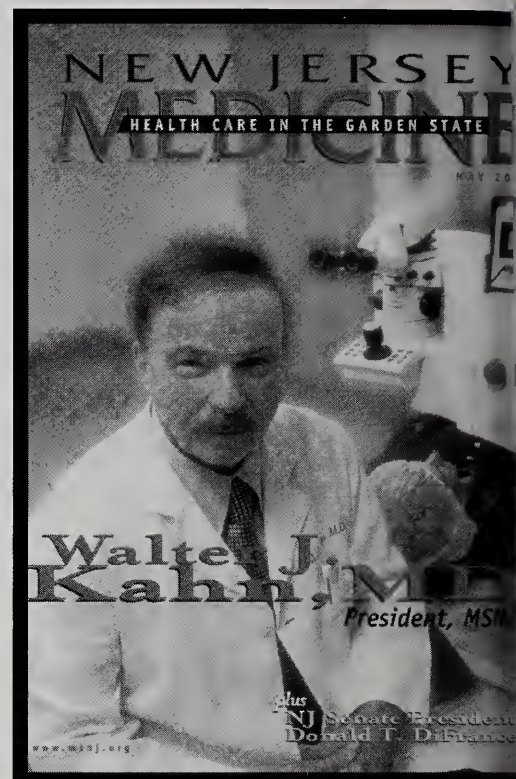
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## CONTROLS OR STRAITJACKETS?

In the MSNJ Editorial section of the February 2000 issue, under "Will Doctors Make the Decisions Again?" Dr. Hirsch strikingly provides us with the reason organized medicine has lost much of its credibility and support with the average medical practitioner. He states, "insurance companies and others will not cease their efforts to control the cost of medical care, *nor should they.*" (Emphasis added.)

To control the cost of medical care, which he believes insurance companies and others should do, it is axiomatic that they must control the practice of medicine. But, isn't this the way of thinking by organized medicine that has produced the straitjackets that physicians have been suffering in for the past 20 years?

*F. Peter Rescigno, MD  
Roseland*

## REASONS FOR TEEN PREGNANCY

As someone who teaches courses in adolescent psychology, I was glad to learn about the HiTops program for promoting adolescent health and well-being ("Teen-friendly services: advocates for successful

teen contraception," by Bonnie L. Parker, RN, 2/00 issue). By stressing confidentiality, accessibility, cost control, and convenience, it possesses all of the features that have made similar programs successful elsewhere.

Research has consistently shown that sex education programs that merely advise abstinence from sex have virtually no impact on sexual behavior. It is essential that teens gain access to contraception and that their confidentiality be respected. Only this approach has resulted in dramatic reductions in pregnancy rates in various countries, including the US, Canada, France, and Sweden.

### Requirements for letters

*To submit a letter, e-mail (info@msnj.org) or mail your letter on disk to New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Letters should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.*

*Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgement. Letters may be published on MSNJ's Web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.*

These programs work because they take into account teenagers' embarrassment about asking for and using contraception. They are not merely informational. In the same vein, an understanding of why the US has such a high rate of unmarried adolescent pregnancy requires an analysis of motivational factors. Evidence indicates that many girls get pregnant not out of ignorance of contraception but because they wish to have a baby and do not foresee marriage as a realistic possibility. In this they are, sadly, often correct. As long as we are content to maintain a high percentage of impoverished, uneducated, unemployable men in our cities, many women will be forced either to be single mothers or to renounce reproduction. In the absence of programs to make more men employable and hence marriageable, efforts such as workfare, child care, and other systems to support unmarried childbearing actually aggravate the breakdown of the family.

*Glenn E. Weisfeld, PhD  
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## WALTER J. KAHN, MD, TO LEAD MEDICAL SOCIETY

Walter J. Kahn, MD, is being inaugurated as president of the Medical Society of New Jersey at Physicians Conference 2000, at the same time that this issue is published. Dr. Kahn brings strong personal assets to the position of president: he possesses demonstrated and proven leadership ability; he is a busy practicing physician and surgeon; and he is a humanitarian who devotes time to improving care in developing nations.

Dr. Kahn has served in many offices in MSNJ, including speaker of the House of Delegates, member of the society's delegation to the AMA, and officer and member of the Board of Trustees. He has an understanding of the many and complex health care issues facing the medical profession and the public. He has been forceful in the advocacy of issues that concern our profession and our patients. Dr. Kahn is especially interested in effective communications with the membership of the society, and we look forward to his impact in this critical area.

In his ophthalmology practice, he has been at the forefront of new surgical procedures and is a hard-working and compassionate physician.

He also provides an outstanding example of selfless commitment to patient care by his service in Project ORBIS, sometimes called the flying eye hospital. He was recently informed that this summer, Project ORBIS will be sending him on another mission, this time to Tashkent, Uzbekistan. Dr. Kahn is characteristically modest about the significant humanitarian work that he performs in developing countries, where he donates his time and services to improve patient care and to teach new techniques of eye surgery to local physicians. In this activity, and in other respects, we believe that he represents the very best that our profession has to offer.

In an interview presented elsewhere in this issue, Dr. Kahn discusses a "three-pronged health care revolution" affecting patient care and changing the way that we practice medicine. We believe that Dr. Walter Kahn has earned the confidence and respect of the New Jersey medical community and that he is ideally suited to lead our profession in the challenging and changing times that are a part of this "revolution."

Paul J. Hirsch, MD



## MSNJ AND MIIX: A STRONG PARTNERSHIP THAT SERVES BOTH

The links between the Medical Society of New Jersey and the MIIX insurance company have been strong from the beginning.

MIIX was conceived by and formed by MSNJ and its membership in response to the malpractice crisis of the late 1970s, when many major professional liability insurance carriers withdrew from this line of business.

Up to and including the present time, most MIIX board members have been physicians. This has been consistent with other doctor-formed professional liability insurance companies. Now, circumstances have changed. To remain strong and to continue to serve the physicians who are its customers, MIIX has become a stock company and is listed on the New York Stock Exchange as The MIIX Group.

It is probable that in the future, some new members of its board may not come from the physician community, but rather from the finance or insurance industries, or other areas in which particular expertise is essential to the board and to the continued success of the company. Some have expressed concern that this might in some way dilute the commitment to its insureds that has been the standard of

the company, in favor of a new preference for its shareholders. As a publicly held company, MIIX certainly has a clear (and legal) obligation to its shareholders. But, as with any business, it recognizes and understands that this obligation cannot be met without also serving the needs of its customers, who are the insured physician policyholders.

MSNJ is the largest single shareholder in MIIX. That relationship is important to both organizations. Involvement in MIIX by leadership of the Medical Society is a source of strength for the company, providing input by key leaders who, by their experience with the company, are informed and knowledgeable about the company itself and the industry in general. And this same involvement provides MSNJ, as a shareholder and as a representative of member insureds, with further assurance that MIIX will continue to meet the needs of insured physicians and serve their interests.

The strong links with MSNJ that were a part of the formation and existence of MIIX continue to serve both.

Paul J. Hirsch, MD [Dr. Hirsch is a member of the Board of Directors of The MIIX Group.]

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# INAUGURAL ADDRESS

THE FOLLOWING IS THE INAUGURAL ADDRESS OF MSNJ PRESIDENT WALTER J. KAHN, MD,

DELIVERED AT PHYSICIANS CONFERENCE 2000, ATLANTIC CITY, MAY 6, 2000

**T**hank you for the chance and the challenge to serve as your president in the coming year. And chance and challenge are what I want to talk about this afternoon.

No, that's not quite true. What I really want to talk about is my mother, Celia Kahn. Nearly 92 years old and still working. Twice a week, from her home in Lakewood, she aims that old Toyota Camry for my office in Red Bank to keep my books and to give me valuable advice.

But it's not what she says that I pay attention to. It's what she does. The example that she and my late father set for me throughout my life. You see, this fancy new convention center in Atlantic City is a long way from where the Kahn family began. It is a long way from 1936, from the small village of Schotten, Germany, and from an increasingly oppressive and hostile government.

You, Mother and Father, grabbed your valuables: your two-year-old

son Walter and 50 dollars (the limit the Nazis allowed you to take out of the country). You took a chance on finding a better life in America. You embraced the challenge that came with building that life. You understood that change—with all the upheaval and all the turmoil that came with it—is not necessarily bad. That it can, instead, be an opportunity—to build a better life, to find a better way than you ever dreamed possible.

And so it is with medicine. Today, we find ourselves in a time of great challenge and enormous change. Some of our colleagues want to quit. But we, the leaders of New Jersey medicine, must not allow that to happen. Let me tell you what I mean. I recall the words of a commentary that I once heard on public radio. The commentator said, "What's with you doctors today, sitting on the sidelines, wringing your

hands, crying in your towel? You are the guys and gals who made it rough for the rest of us in high school. You made the honor roll. You set the curve. You were always the ones telling the rest of us what to do and how to do it. Where are you today in this health care mess? Why don't we hear from you? It's time you got back in the game. We counted on you then, and we're counting even more on you now, to put those brains and that fine education to good use. Help us reclaim control of our medical care."

That commentator was right. We are the can-do take-charge guys. And it is time that the physicians of New Jersey did just that: help our patients and our profession put health care decision-making back where it belongs. You have all heard former AMA President Daniel "Stormy" Johnson say it so well: "It is time to put the patient back in the driver's seat, with the doctor riding shotgun."



But before we do that, we have a little housekeeping to attend to. We have got to reunify. I don't know about you, but I am so tired of the many in our ranks that have added an adjective to their titles. You know what I mean. Doctors who say, "I'm a primary care physician, an academic physician, a group practice physician, a solo practice physician, a family physician, an administrative physician, a research physician."

We are, first, last, and foremost, simply, physicians. We have so much more in common than we have in conflict. We must begin emphasizing our common goals, our common values, not our current differences.

A good start is this Physicians Conference 2000. It is an excellent opportunity to open the tent to all New Jersey physicians, to all modes of practice, and to varied concerns. This is a chance to rise above parochial interests and break down artificial barriers. When we work together, we can accomplish so much.

Look at what we won when we all pulled together in Trenton to win the first step toward a meaningful Patients' Bill of Rights. And when we joined together again to fight off the insurance industry and to pass the prompt-pay bill. Now think what we can accomplish if we bring that same concerted effort to bear on the state action doctrine. That radio com-

mentator was right: we must get off the sidelines and back in the game. And we must do it now.

We must get back in the game with a renewed positive attitude. In the hospital hallways and at medical society meetings, I hear a lot of pessimism and defeatism, which frustrates me as a medical leader.

I enjoy reading military history. In many armies, bad attitude was a capital offense. They shot you for it. They understood how infectious attitude is, whether good or bad. We physicians must have an attitude adjustment. We must learn to dwell on the positive. We must bring our thinking and energies to focus on what we can do, what we can achieve. As a medical society, we must work to make sure that not just our member physicians but all New Jersey physicians see us as responsibly aggressive. What do I mean by that? I mean that we are willing to take risks for our patients and our profession, whether it is in Trenton in the legislature or in the courts. We can, we must, we will make a difference. Like many of you, I feel blessed by what life in medicine has given me. And, like many of you, I enjoy giving back, volunteering in some way. Since 1984, I have participated in Project ORBIS, the flying eye hospital that brings modern surgical techniques to developing countries. From West Africa to China and from

Haiti to the Philippines, I have had the opportunity to see first-hand not only the medical systems but also the governmental systems of these many countries.

My observation is that we are lucky here in this country.

We are fortunate to have a say in how things are run. And we are given the opportunity to mold change and to help make decisions. Shame on us when we do not take advantage of that opportunity. Shame on us when we do not support the Medical Action Committee (MEDAC) and the New Jersey Medical Political Action Committee (JEMPAC), when we do not fax or phone or e-mail our legislators and regulators, when we do not take advantage of helping shape the end product and of being our patients' and our profession's advocate.

You know, I began talking about my mother and father and how much I admire and appreciate the example they set for me, of understanding that challenge is not necessarily bad, that change can be good. And that positive attitude is the first step toward success.

I pledge as your new president to spend this next year helping you make a difference in the lives of our patients and our profession. I look forward to working with you. 

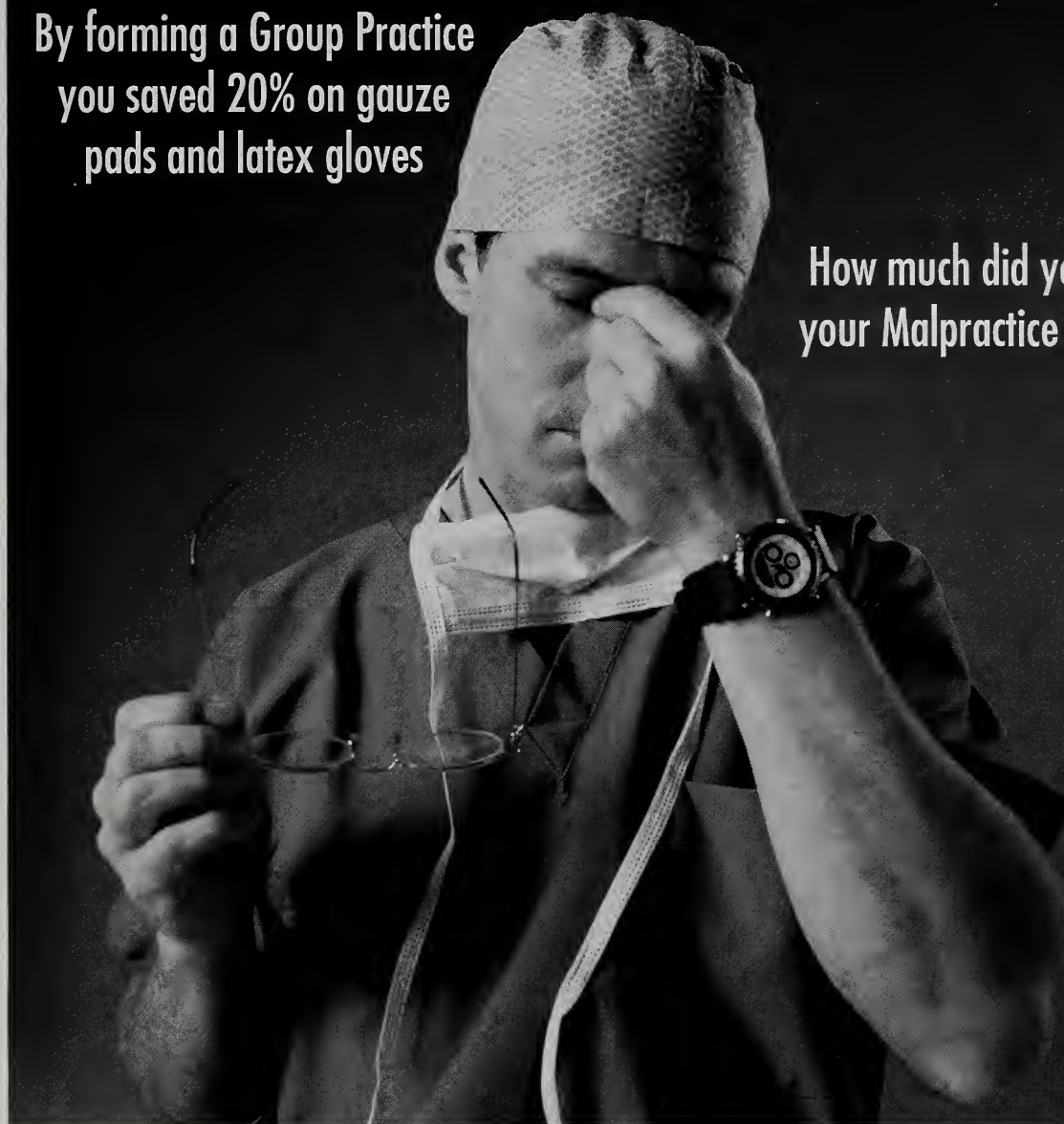
*Walter J. Kahn, MD*

*Inaugural Address*

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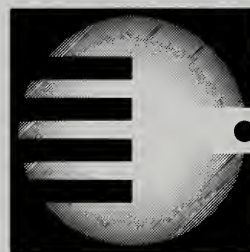
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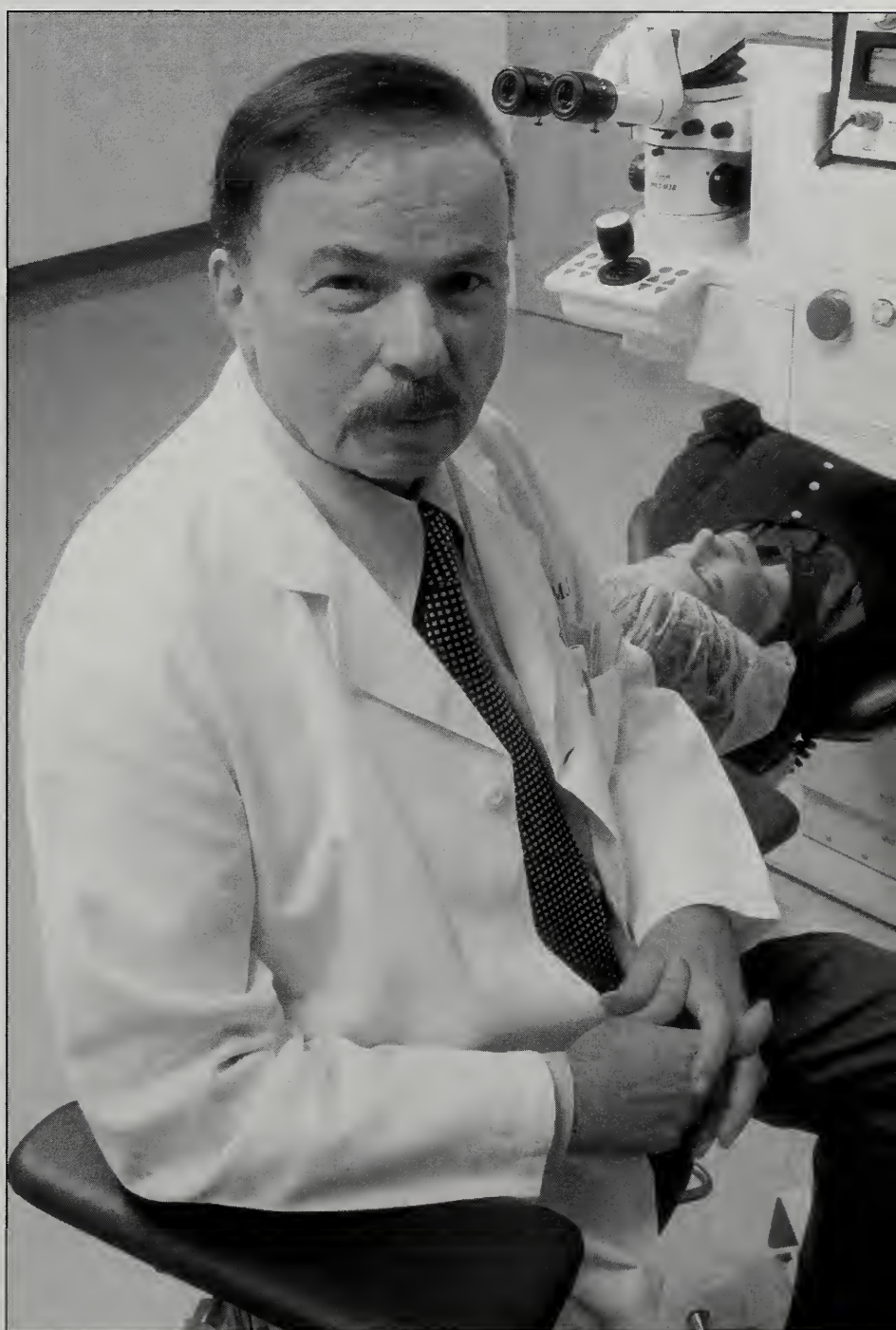
# Walter J. Kahn, MD

*President, the Medical Society of New Jersey*

**W**alter J. Kahn, MD, president of the Medical Society of New Jersey for the 2000-2001 year, has been a prominent medical leader in New Jersey and nationally for many years. He has served as speaker of the House of Delegates and as a member of the Board of Trustees of the Medical Society for the past five years and has been on New Jersey's delegation to the American Medical Association since 1991.

He is a busy practicing ophthalmologist in Red Bank and plans to maintain his active practice during his MSNJ presidency.

*New Jersey Medicine* (represented by MSNJ Executive Director Vincent Maressa and Editor-in-Chief Paul Hirsch, MD) interviewed Dr. Kahn at MSNJ headquarters in Lawrenceville a short time before he was to take office as president. He indicated pride in the achievements of the Medical Society of New Jersey but felt that the society does not adequately communicate its record of accomplishment and the benefits of membership. He is determined to improve communications with the membership and with the county medical societies. Dr. Kahn also believes strongly in the need to understand and be responsive to the concerns of the practicing physicians in New Jersey.





**New Jersey Medicine:** Dr. Kahn, you have been an MSNJ leader for many years now and have a strong sense of the strengths and achievements of the society. Would you discuss these for us?

**Dr. Kahn:** We have many strengths. We have many talented and resourceful leaders on our Board of Trustees and our Councils. We have a capable and multitalented staff. We have excellent communications with the Department of Health and Senior Services, the Department of Banking and Insurance, and the Board of Medical Examiners, as well as with the legislature and the governor's office. We are the only voice in the state that speaks for all physicians.

Our AMA delegation has been in the forefront of the American Medical Association, and we have had a significant impact on the AMA and its House of Delegates. Our delegation is always prepared and informed about the issues and is forceful about representing New Jersey physicians on the floor of the AMA House of Delegates.

Another strength is MIIX. MSNJ created a strong insurance company, and we have had an excellent and symbiotic relationship over the years, which has been beneficial to the society. Now that MIIX is a public company, it is stronger and even better able to meet the needs of physicians in New Jersey and elsewhere. MSNJ is the largest single

shareholder of MIIX, and this investment is an important resource and strength.

But many of our achievements are not visible. For example, when a provider tax was being considered, we were instrumental in making it disappear. The ability to erase problems before they even appear is very important, and it is a critical aspect of what the society can do for the membership. Other recent achievements include the prompt-pay bill and the patient-protection act.

**NJM:** Does the organization have weaknesses that concern you?

**Dr. Kahn:** One of our weaknesses is communication. We do not effectively communicate our strengths to the members. We are actively working to improve this, and a new communication plan is in development now.

Another weakness is in our structure. The state society and the county societies sometimes act independently and separately and do not complement each other. We must eliminate the rivalry that sometimes seems to occur between the state society and the county medical soci-

eties. We also need to work more effectively and cooperatively with the specialty societies.

**NJM:** Dr. Kahn, would you expand on your comment about the relationship between MSNJ and the county medical societies?

**Dr. Kahn:** We are now in the midst of a study by a consulting firm, reviewing the operations of the society and our relationships with the county medical societies.

In addition, I am concerned that the smaller counties cannot support strong, successful organizations. Any county with fewer than 250 members probably could be more effective if it shared resources with other counties.

**NJM:** You have a great deal of experience as speaker of our House of Delegates. Under our resolution process, members may observe what they believe is a problem and then wait many months for the meeting of the House of Delegates to present it. Should we have a process in which individual members, perhaps through the county societies, could bring potential problems to the Board of Trustees at an earlier time?

**Dr. Kahn:** This is a very important issue. Even now, individuals and county societies can bring problems before the board at the monthly meetings for action or for referral to the appropriate council. This could eliminate some of the "untimeliness" of the present resolution process. In addition, it would

WE HAVE MANY  
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THAT SPEAKS FOR ALL  
PHYSICIANS.

allow a more thorough evaluation of the resolution by an MSNJ council or committee before being reported back to the board or even to the House of Delegates.

**NJM:** Another difficulty is that many of the "Whereas" statements in the resolutions are inaccurate, and yet we have no process to evaluate this. Although our House of Delegates is formally voting on the "Resolved" paragraphs, the "Whereas" paragraphs are part of the document and of course available to the press as well as others.

**Dr. Kahn:** We could perhaps have a better screening process for the resolutions. Nevertheless, although it is a cumbersome process, it gives delegates a direct voice and seems to work. Many of the resolutions are a reflection of the climate that we are in.

**NJM:** As our new president, you may be in the position to lead our society after passage of state legislation that would allow us to negotiate collectively. How do you believe this would affect the practicing physicians of New Jersey?

**Dr. Kahn:** One of the most important issues right now is the abuse by and heavy-handedness of the insurance companies. We are virtually powerless today. We need some kind of collective negotiation, not just for reimbursement but for the way the entire system operates: what the patient deserves, what the patient is entitled to, emergency

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room problems, point-of-service problems, retroactive denials. The insurance industry stands between our patients and us. There is a real need for reform. Lack of portability of insurance plans and denials of insurance for those with preexisting conditions were among the issues that ignited calls for health care reform.

We must restore a balance of power on behalf of our patients. I believe that the state bill that would allow collective negotiations will go a long way toward helping to correct these problems. I am pleased that it has been introduced in the legislature and is publicly supported by the senate president.

**NJM:** If that legislation is indeed passed, what role do you see the MSNJ playing?

**Dr. Kahn:** Of course, we must see the form the law may take. However, our society must assume as strong a role as the law will allow on behalf of our members and their patients. I am hopeful that it will

give us a greater voice and greater strength vis-à-vis the insurance companies. One problem now, for example, is that we often cannot get a fee schedule from a carrier. No other group or industry works without a fee schedule.

**NJM:** Dr. Kahn, if you could look forward a year, what are some of the accomplishments that you would like the society to have achieved during that time?

**Dr. Kahn:** I would like to see a better relationship between our society and the county and specialty societies. I would like to encourage physicians to maintain a positive attitude with regard to our profession, despite the difficulty of doing so in this climate. And I would like to impress on people that we are in an era of rapid change, which creates anxiety, and we must deal with these changes.

We are really in the midst of a three-pronged health care revolution. First, there is a technological revolution with fantastic medical advances. For example, in my field, ophthalmology, I would never have imagined a few years ago that we would be able to eliminate the need for glasses by using a laser. Second, we are also undergoing a revolution in health care delivery, because of changes in payment systems. And third, because of the information revolution and the information available on the Internet, many peo-



ple are downloading their medical information to their home computers and may even receive their treatment programs from this source. Physicians must adjust to these changes and use them in the best interests of their patients.

**NJM:** You have spent the past year as chair of our membership committee. What can we do to enhance membership, bring in new members, and retain our current members?

**Dr. Kahn:** We must restructure the system to recruit and hold members. Members must be helped to realize the value of membership. This is a component of communication.

I am convinced that we do indeed provide excellent value for membership, but the members do not know what we have done for them. Members are often not aware of specific programs we provide, such as contract review. It also will require more cooperative efforts between the county societies and us, and I hope that the current study will address that problem. We should also continue to pursue such initiatives as discounts for group membership and programs for individual practitioners—for example, if a member signs up for five years we might offer one year free.

**NJM:** Dr. Kahn, we know that you have done exciting work in underdeveloped countries for many

years. What organization do you work with?

**Dr. Kahn:** The organization, which has been in existence since the early 1980s, is Project ORBIS, sometimes called the flying eye hospital. It is a private organization, heavily sponsored by corporations, and receives some government money and some funds from the Agency for International Development.

We introduced advanced surgical techniques to developing countries. We are completely self-equipped, so that we can fly in and teach local surgeons to perform procedures that will alleviate blindness and partial blindness. There are more than 180 million people who are blind, partially blind, or at risk of becoming blind. Our mission is to alleviate that condition.

**NJM:** After Project ORBIS leaves an area, how do patients continue to

benefit from the technology that you have brought in?

**Dr. Kahn:** We encourage the local surgeons and health care workers to use the new technology that we have taught them. We also leave equipment behind for them, if necessary. And then we send follow-up teams to these countries. Finally, we have land-based teams that follow up with the local hospitals. It all depends on the needs of the country.

We do not fly in and fly out. There is a lot of follow-up. There is a lot of preliminary work that we do before we go. First, we must be invited into the country. Then, we have to find out what they want us to do and what resources they already have. It is a very expensive program, but it is also very comprehensive and has a major impact.

Project ORBIS has flown nearly 400 missions. The DC-10 that has been used for these missions for the past few years is really our teaching hospital. It is very well equipped, with a lecture room, an operating room, videotaping equipment, an examination area, and a laboratory.

**NJM:** How many of these missions have you personally gone on?

**Dr. Kahn:** I try to go once a year and have been on at least eight missions. Some of the places that I have gone to with Project ORBIS are Ulan Bator, Mongolia; Riga, Latvia; Port-au-Prince, Haiti; Hefei,

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China; and Calcutta, India. Each mission is at least three weeks, but the faculty is rotated every week, and I generally go for about 10 days.

I am still sometimes amazed at how much we can accomplish in a short time. We do a great deal while we are there, treating patients and teaching; and we leave a great deal behind in the way of trained personnel and goodwill. We are sometimes invited into countries where the United States is otherwise not necessarily welcomed, and the goodwill that we create for our country is an important secondary benefit.

**NJM:** Are you compensated for your time?

**Dr. Kahn:** No, but some expenses are paid, and United Airlines usually provides transportation. The only people who fly on the ORBIS plane are the permanent staff of nurses and technicians, usually about 25 people.

**NJM:** Do you plan to go again this year, during your presidency?

**Dr. Kahn:** Yes. It is important work, and I get a great deal of satisfaction and enjoyment from it. I think that I would have withdrawal symptoms if I didn't go. It gives me a chance to see other medical systems. It is refreshing to practice medicine in this way. You have the opportunity to contribute something. People appreciate you. And there is not much paperwork involved. We have

**WE MUST ELIMINATE THE RIVALRY THAT SOMETIMES SEEMS TO OCCUR BETWEEN THE STATE SOCIETY AND THE COUNTY MEDICAL SOCIETIES.**

so much, and they have so little, that we have a responsibility to share.

I have also had a chance to see what can happen in government-dominated systems of medical care, where there are no incentives. When there is very low compensation for physicians, there is often a very low output of work, despite desperate need.

**NJM:** An important issue facing the medical profession is the size and continued growth of the physician workforce. Would you comment on this?

**Dr. Kahn:** We have a definite oversupply of physicians, at least in New Jersey, but probably throughout the country. It is important that there be a national policy with regard to this, and we should try to promulgate or facilitate it. A good place to start, and a policy that has never been initiated at the AMA, is to limit the residency slots to no more than 110% of the present level. The residency level seems like the right place to start. If all residency programs that are truly primarily

educational were retained and those that are primarily service oriented were eliminated, we could make a dent in the problem.

We cannot keep producing doctors at the current rate. There are too many doctors being produced. Only the insurance companies benefit from this oversupply; patients do not. But it will take many years for any change to have its effect.

**NJM:** Many physicians feel discouraged about practicing medicine today. Do you?

**Dr. Kahn:** I'm delighted to be able to say that I still find my practice interesting and rewarding. My field of ophthalmology has had very exciting advances, such as the eximer laser for refractive surgery. We can make our patients extremely happy in a few minutes and do away with their contact lenses or glasses for the most part. It is new and fascinating technology. And there really is new technology in virtually every medical field today; this is just one, in my own specialty. It keeps me interested and stimulated, and it is one reason that I am still in full-time practice and enjoy it.

Just the other day, I performed the LASIK surgical procedure on a woman. She got up, looked around, and said "Oh my God, I can see." And then she turned to me and she said "Doctor, you have a fun job." That really struck me, because it described what I do. I have a fun job.



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# COMPREHENSIVE HEALTH CARE REVIEW IS LEGISLATIVE PRIORITY

*Senate President Donald T. DiFrancesco*

Consider this fact: the largest purchase that many American families will make in their lifetime is no longer their home but their health care. Is it any wonder then that in a recent *Star-Ledger/Eagleton-Rutgers* poll, 68% of New Jersey residents thought health care was going to become less affordable in the future?<sup>1</sup>

We all know the story. In fact, we either have lived the story ourselves or have heard the stories of thousands of New Jersey citizens who have shared their concerns, their complaints, and even their catastrophes in dealing with modern health care.

New Jersey's health care system is in need of emergency treatment, and it is time for the legislature to intervene. I have asked the Senate Health Committee to undertake a comprehensive review of the state's health care system from top to bottom.

For the purposes of this review, I have asked the committee to examine the system in four broad topical areas: The first one is health insurance—more precisely, keeping it affordable and accessible. How can we continue to promote the highest-



*Senate President Donald T. DiFrancesco*

quality health care at prices New Jerseyans can afford?

The second issue is the condition of our hospitals. We need to give them the tools they need to be financially competitive while delivering the quality care that New Jerseyans have come to rely on.

The third area concerns provider issues. We need to empower physicians and other providers to be the primary medical decision-makers for patients.

And the fourth area involves ensuring quality health care for every segment of our diverse community, from seniors to children to the minority population.

On health insurance, the committee will examine how the state can

encourage more private associations to self-insure, promote greater variety in health benefit plans, and expand the use of medical savings accounts. It is also critical that we give serious consideration to the law governing HMOs in New Jersey, which dates back to the early 1970s.

Some people have suggested shifting the decision of determining medical necessity from HMOs to patients and their physician. Some want to examine the possibility of the right to sue HMOs. The committee will consider the feasibility of both.

Most important, we should take another look at our Health Care Quality Act, this state's Patients' Bill of Rights, to see if it is truly providing adequate protection. And in light of HMO insolvencies, the committee should review the state's ability and authority in scrutinizing the operations and financial position of HMOs.

No reform of our health care system is possible without addressing fundamental problems in the hospital system. As an example, on any given day, 30% of the state's 30,000 beds are empty, and our hospitals have the highest length of stay for Medicare patients. And while the



financial performance of many hospitals has improved, New Jersey hospitals have a higher level of debt and lower level of cash than the national average.

How do we promote better use of beds, space, and staff and the development of cost accounting systems? How do we assist hospitals in streamlining their accounting procedures and in providing them with more flexibility in billing? We need to explore ideas to help hospitals do their job better, such as increasing Medicaid reimbursement rates. And we must help them be more efficient.

Of course, New Jersey physicians have a number of concerns that also need to be examined, with priority given to the question of Medicaid reimbursement. The reimbursement rate has been unchanged for a long time. A revision of Medicaid fees should be discussed for physicians as well as for hospitals.

Another issue is a measure introduced in February by Senator Martha Bark. Senator Bark's bill would authorize the Attorney General to permit providers to join together to negotiate medical quality of care issues and provider reimbursement rates with an insurer that has market dominance in a geographic area. I support this concept, and I have assigned this bill to the committee for consideration of its merits.

For our senior population, quality health care often depends on a daily regimen of prescription medications. Unfortunately, the greatest annual increase in the cost of medication has been in the medications most often used by seniors. It is an

HOW DO WE PROMOTE  
BETTER USE OF HOSPITAL  
BEDS, SPACE, AND STAFF  
AND THE DEVELOPMENT  
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STREAMLINING THEIR  
ACCOUNTING PROCEDURES  
AND IN PROVIDING THEM  
WITH MORE FLEXIBILITY  
IN BILLING?

issue that the federal government is looking to address, but I have also asked the committee to make helping seniors a priority concern this spring.

For the minority community, evidence has shown that there is a significant disparity between the quality of their overall health care compared with the rest of our state's population. True health care reform cannot be achieved unless we begin to meet the needs of New Jersey's diverse communities. The key to this issue may be found within the state's Office of Minority Health, an office that we should consider expanding or funding at a higher level.

Finally, the future of health care is right here. As the leading center of pharmaceutical and biomedical research, New Jersey is at the fore-

front of tomorrow's medical and technological breakthroughs. The extent to which we, as a legislature, can create opportunities or incentives to promote such research, we should and we will. For all of our efforts in the State House, the answer to better health will ultimately be found in the lab.

New Jersey can be proud of its record on health care, including such landmark initiatives as hospital deregulation, guaranteed access to insurance coverage, KidCare, and the Health Care Quality Act.

But with lives literally hanging in the balance, we cannot afford to say that our job is done. It is not done, nor will it be, until we begin to leverage the successes we have achieved and remedy the failings we know exist in our health care system.

*Donald T. DiFrancesco is president of the New Jersey Senate and senator from the 22nd legislative district. In 1983 he sponsored legislation creating a special fund to help families pay for extraordinary medical expenses incurred by their children's catastrophic illness. The Catastrophic Illness in Children Relief Fund is the only comprehensive relief program of its kind in the nation. In 1989 he sponsored the New Jersey Family Leave Act, the model for a federal law that protects the jobs of workers who take leaves of absence to care for seriously ill family members. He also sponsored legislation that created KidCare, a state-subsidized health insurance program for New Jersey's neediest children.*

## References

1. Whither New Jersey? How the public expects the quality of life in the Garden State to change over the next decade. *Star-Ledger/Eagleton-Rutgers poll*: December 26, 1999.

# GASLESS VERSUS CONVENTIONAL LAPAROSCOPY

*A randomized single-blinded clinical trial comparing gasless laparoscopy employing the laparolift device with conventional laparoscopy employing pneumoperitoneum in gynecologic surgery*

THE OBJECTIVE OF OUR STUDY WAS TO EVALUATE THE TECHNICAL ADVANTAGES OF USING THE LAPAROLIFT DEVICE AND EXAMINE THE CLINICAL BENEFITS OF GYNECOLOGIC LAPAROSCOPY WITHOUT PNEUMOPERITONEUM. A RANDOMIZED SINGLE-BLINDED CLINICAL TRIAL WAS PERFORMED EMPLOYING A SAMPLE OF 30 CONSECUTIVE PATIENTS UNDERGOING LAPAROSCOPIC GYNECOLOGIC SURGERY WITH A PRIMARY OUTCOME MEASURE OF VISUALIZATION. VISUALIZATION WAS FOUND TO BE INFERIOR IN GASLESS PATIENTS. THE CONCLUSION WAS THAT CONVENTIONAL LAPAROSCOPY EMPLOYING PNEUMOPERITONEUM PROVIDES SURGICAL EXPOSURE SUPERIOR TO THAT OFFERED BY THE LAPAROLIFT DEVICE.

*James Chivian Lukban, DO; Joseph Jaeger, MPH; Kelly C. Hammond, MD; Dominic A. LoBraico, DO; Ana-Maria C. Gordon, MD; Robert A. Graebe, MD*

Developed as an alternative to conventional laparoscopy, the Laparolift device (Origin Medsystems, Inc., Menlo Park CA) offers visualization of the abdominopelvic cavity through mechanical peritoneal retraction without requiring pneumoperitoneum. Such gasless laparoscopy eliminates potential blood gas, hemodynamic, and ventilatory changes encountered with the infusion of carbon dioxide insufflation. The absence of gas also removes the risk of gas embolism, subcutaneous emphysema, and deep venous thrombosis as a result of pneumoperitoneum-induced ven-

ous stasis.<sup>1-8</sup> It is also thought that a gasless environment may reduce postoperative abdominopelvic and shoulder pain through the absence of both carbonic acid formation on peritoneal surfaces and diaphragmatic irritation. Most data regarding the benefit of mechanical peritoneal retraction, however, has been anecdotal, with only a few randomized prospective studies confirming its theoretic advantages. Our study prospectively evaluates the technical advantages of using the Laparolift device and examines the clinical benefit of gynecologic laparoscopy without pneumoperitoneum.

## MATERIALS AND METHODS

### Patients

Thirty consecutive women requiring laparoscopic gynecologic surgery at Monmouth Medical Center participated in this randomized single-blinded clinical trial from April 1994 to October 1994. The study was carried out under institutional review board approval. Appropriate preoperative consent was obtained from all patients. Fifteen women were randomized to the Laparolift (gasless) group and fifteen to the pneumoperitoneum (carbon dioxide, CO<sub>2</sub>) group.



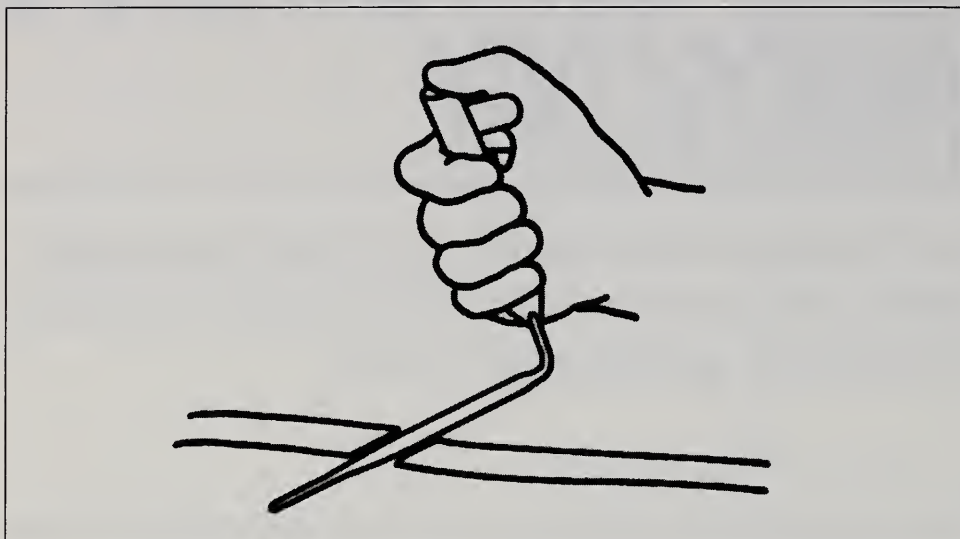


Figure 1. The Laparofan is introduced through an umbilical incision with the fan blades closed.

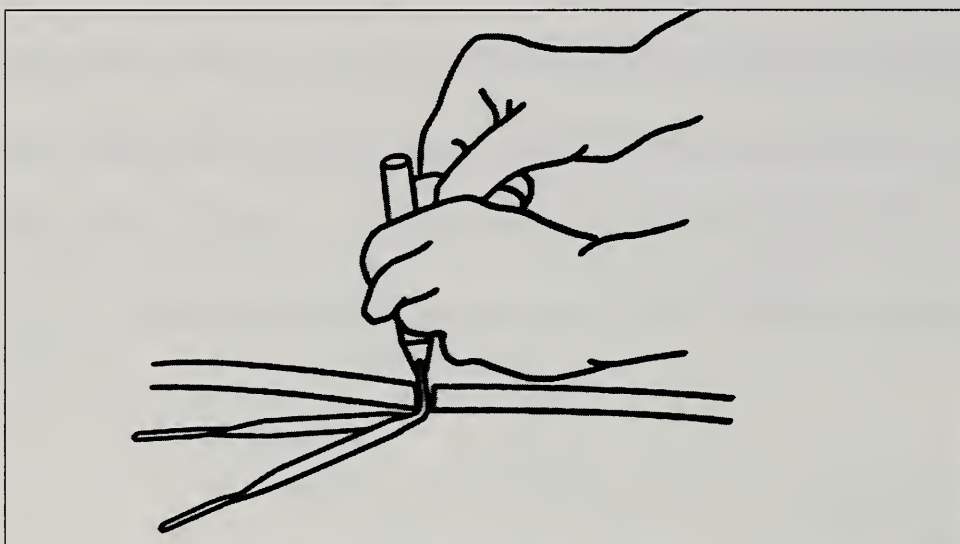


Figure 2. The fan blades are opened and locked to assume a triangular configuration.

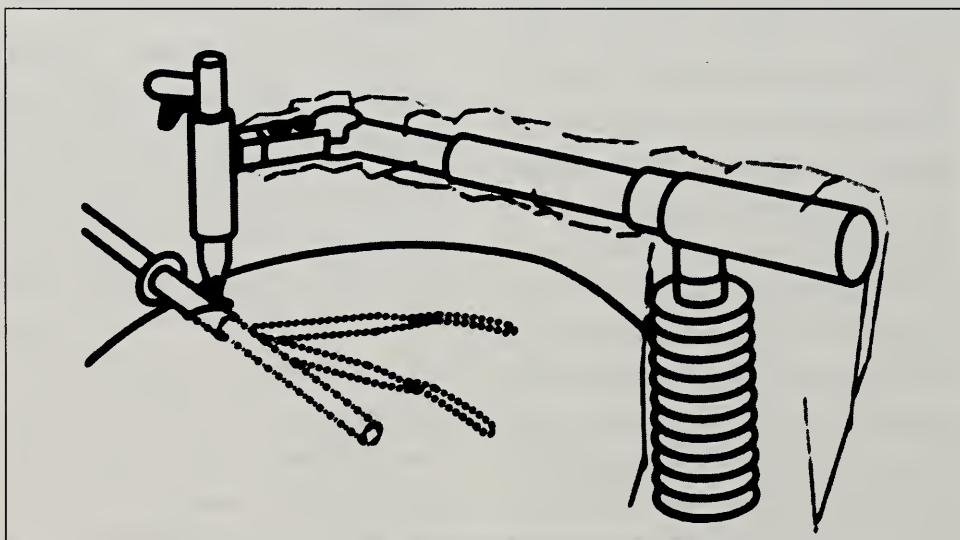


Figure 3. The Laparofan is then coupled with an electrically powered lifting arm, attached to the operating room table at the level of the patient's shoulder, opposite the primary surgeon.

Group allocation was achieved by opening a sequentially numbered, opaque, sealed envelope containing a randomized group assignment on the day of surgery.

### Surgical Technique

An open technique as originally described by Hasson was used to gain initial access to the abdominal cavity in all patients, employing a 1.5-cm vertical umbilical incision.<sup>9</sup> A 10-cm Origin fan retractor was introduced at the umbilical site in the gasless group (Figures 1 and 2). A 10-mm blunt-tipped Origin trocar was used in the CO<sub>2</sub> group. Additional ports were placed as needed both suprapubically and laterally. Setup and operation of the Laparolift device was as that previously described by Chin et al. (Figure 3).<sup>10</sup> Insufflation in the CO<sub>2</sub> group was limited to a pressure of 15 mm to 20 mm Hg.

### Evaluation

One of four surgeons (JCL, KCH, DAL, RAG) evaluated the quality of visual field, following appropriate lysis of adhesions, employing a scale from 1 to 10, with 1 being the worst and 10 the best score given. Considerations in score assignment included each operator's assessment of the following: adequacy of bowel displacement from the pelvis; degree of anterior and lateral abdominal wall distention; and exposure of abdominal and pelvic peritoneal surfaces.

Anesthesia personnel recorded standard clinical parameters both intraoperatively and postoperatively.

| Diagnosis                                   | Gasless<br>(n = 15) | CO <sub>2</sub><br>(n = 15) |
|---------------------------------------------|---------------------|-----------------------------|
| Pelvic pain                                 | 7 (46.7)            | 13 (86.7)                   |
| Infertility                                 | 2 (13.3)            | 0                           |
| Uterine leiomyomata                         | 2 (13.3)            | 0                           |
| Adnexal mass                                | 1 (6.7)             | 0                           |
| Ectopic pregnancy                           | 1 (6.7)             | 0                           |
| Habitual abortion                           | 1 (6.7)             | 1 (6.7)                     |
| Voluntary sterilization                     | 1 (6.7)             | 1 (6.7)                     |
| Data is presented as number (%) of patients |                     |                             |

Table 1. Indications for Laparoscopy by Surgical Technique.

Postanesthesia care unit (PACU) and same-day surgery (SDS) staff recorded data on immediate postoperative pain, postoperative nausea, time to liquid tolerance, time to first void, and time to discharge. Postoperative pain was rated by the patient on a scale from 1 to 10, with 1 being the least and 10 being the greatest degree of discomfort.<sup>11</sup> All patients were questioned within 10 minutes of their arrival to the PACU after having received 30 mg of ketorolac tromethamine (TORADOL, Roche Laboratories, Nutley NJ) IM or IV approximately one-half hour before the completion of the procedure. Nausea was assessed by nursing personnel and assigned a rating of none, mild, moderate, or severe. Time to liquid tolerance, time to first void, and time to discharge were recorded in hours.

## Statistics

Data was analyzed according to the intention-to-treat principle.<sup>12</sup> The Mann-Whitney U test was employed for analysis of nonparametric data; the chi-square test was used to ana-

lyze categorical data. Statistical significance was considered at  $p \leq 0.05$ .

## RESULTS

A total sample of 30 patients was accrued, with 15 patients in the gasless group and 15 patients in the CO<sub>2</sub> group. Indications for laparoscopy are listed in Table 1. None of our patients was diagnosed with malignant disease or possessed a significant medical condition affecting her perioperative course. No significant difference in age [given as (median {range}) in years] was found between gasless (33.0{21-48}) and CO<sub>2</sub> patients (31.0{19-40}), nor was there a significant difference in weight: 125{86-210} versus 132{105-255} pounds.

Visualization, our primary outcome measure as rated by scores from 1 to 10, was found to be less than optimal (median{range}) in gasless patients compared with those receiving CO<sub>2</sub> insufflation: 6{1-10} versus 8{8-10};  $p = .012$ . Three gasless patients required conversion to pneumoperitoneum as a result of

inadequate visualization. In one case the cul-de-sac could not be fully evaluated because of poor bowel displacement, and in two cases adequate abdominal wall retraction was not achieved as a result of patient obesity.

Recording of standard intraoperative and postoperative anesthesia parameters revealed no statistically significant differences between the two groups except for end tidal (ET) CO<sub>2</sub>, PACU temperature, and SDS temperature; the CO<sub>2</sub> group exhibited a higher ET-CO<sub>2</sub> and a lower postoperative temperature (Table 2).

A statistically significant greater degree of postoperative pain (median{range}) was found in gasless patients when compared with CO<sub>2</sub> subjects as rated by a visual analog pain scale from 1 to 10 : 7{1-10} versus 3{1-6};  $p = .022$ .

No statistically significant differences were found between the two groups with regard to length of surgery, time to liquid tolerance, time to first void, or time to discharge (Table 3). Neither group showed a high percentage of patients with severe postoperative nausea.

## DISCUSSION

In recent years, a number of abdominal wall-lifting devices have been created as alternatives to conventional laparoscopy in an effort to minimize or eliminate pneumoperitoneum, because carbon dioxide insufflation has been associated with a range of blood gas, hemodynamic, and ventilatory



| Variable                  | Gasless<br>(n = 15) | CO <sub>2</sub><br>(n = 15) | p     |
|---------------------------|---------------------|-----------------------------|-------|
| ETCO <sub>2</sub> (mm Hg) | 29.0 (26.0-36.0)    | 32.0 (30.0-38.0)            | 0.005 |
| SaO <sub>2</sub> (%)      | 100.0 (92.0-100.0)  | 100.0 (95.0-100.0)          | NS    |
| OR heart rate (bpm)       | 64.0 (56.0-80.0)    | 66.0 (58.0-98.0)            | NS    |
| OR BP systolic (mm Hg)    | 108.0 (98.0-136.0)  | 110.0 (98.0-128.0)          | NS    |
| OR BP diastolic (mm Hg)   | 66.0 (54.0-80.0)    | 77.0 (56.0-86.0)            | NS    |
| OR temperature, low (C)   | 35.3 (34.6-37.7)    | 35.6 (34.2-36.1)            | NS    |
| PACU heart rate (bpm)     | 70.0 (54.0-86.0)    | 70.0 (58.0-78.0)            | NS    |
| PACU BP systolic (mm Hg)  | 110.0 (90.0-144.0)  | 110.0 (102.0-124.0)         | NS    |
| PACU BP diastolic (mm Hg) | 64.0 (50.0-82.0)    | 64.0 (52.0-80.0)            | NS    |
| PACU temperature, low (C) | 35.8 (34.6-36.6)    | 35.3 (33.7-36.0)            | 0.031 |
| SDS heart rate (bpm)      | 76.0 (60.0-80.0)    | 72.0 (60.0-80.0)            | NS    |
| SDS BP systolic (mm Hg)   | 110.0 (90.0-120.0)  | 110.0 (90.0-136.0)          | NS    |
| SDS BP diastolic (mm Hg)  | 70.0 (60.0-80.0)    | 68.0 (60.0-80.0)            | NS    |
| SDS temperature, low (C)  | 36.6 (36.0-37.3)    | 36.3 (35.8-37.0)            | 0.023 |

bpm = beats per minute; C = degrees Celsius  
Data is presented as median (range).  
NS = not significant.

Table 2. Anesthesia Values by Surgical Technique

changes potentially detrimental to patients undergoing laparoscopic surgery.<sup>13-19</sup> Significant increases in arterial carbon dioxide (PaCO<sub>2</sub>) or ETCO<sub>2</sub> or both have been reported and are most frequently the result of peritoneal absorption of gas.<sup>7,20-27</sup> Tachycardia and hypertension have been observed and are thought to be partly a catecholamine-mediated response to hypercarbia,<sup>25,28</sup> and

partly the result of an increased intraabdominal pressure secondary to pneumoperitoneum. A decrease in functional residual capacity has also been observed secondary to impaired diaphragmatic excursion as a function of abdominal insufflation.

In our study, the presence of pneumoperitoneum was found to contribute to a statistically signifi-

cant higher ETCO<sub>2</sub>; however, concomitant changes in heart rate and blood pressure were not observed. As CO<sub>2</sub> patients still maintained ETCO<sub>2</sub> measurements within normal range, the statistically significant elevation in ETCO<sub>2</sub> encountered in this group was without clinical significance. The lower postoperative temperatures observed in our CO<sub>2</sub> patients were most reasonably

| Parameter                | Gasless<br>(n = 15) | CO <sub>2</sub><br>(n = 15) | p  |
|--------------------------|---------------------|-----------------------------|----|
| Length of surgery        | 1.92 (0.75-5.17)    | 1.58 (1.08-2.92)            | NS |
| Time to liquid tolerance | 2.33 (1.17-7.33)    | 4.83 (1.17-8.17)            | NS |
| Time to first void       | 4.25 (1.17-46.50)   | 4.66 (1.83-8.58)            | NS |
| Time to discharge        | 6.25 (3.08-72.00)   | 6.00 (4.25-9.00)            | NS |

Data is presented as median (range), in hours  
NS = not significant

Table 3. Perioperative Parameters by Surgical Technique

the result of corporeal cooling as a sequela of gas insufflation. This finding was also of little clinical significance, because the postoperative clinical course of this patient segment was without aberrancy.

The absence of CO<sub>2</sub> insufflation in contributing to reduced postoperative pain was not realized in this study; gasless patients actually exhibited a greater degree of postoperative discomfort. Reliable and uniform characterization of pain, however, was not offered by most of the patients. Specific complaints of midline lower abdominal pain or point-tenderness may have given better insight as to the likelihood of fan retractor trauma in contributing to patient discomfort.

In two early studies examining gasless laparoscopy, intraoperative visualization with the Laparolift was noted to be at times less than optimal.<sup>10,19</sup> Chin et al. reported the requirement of conversion to pneumoperitoneum as a result of poorly displaced bowel in 1 out of 29 gynecologic patients undergoing either a diagnostic or operative procedure.<sup>10</sup> Hill et al. reported no failures in a group of 20 patients, although the employment of additional ports was required on occasion to manipulate bowel that had prolapsed into the cul-de-sac.<sup>19</sup> Our findings in regard to gasless visualization were similar. One out of 15 gasless subjects required conversion to pneumoperitoneum secondary to a preponderance of bowel in the cul-de-sac, while seven others required adjunctive measures to displace bowel to enable completion of the

procedure. Such measures included the placement of additional ports or the use of multiple instruments through a single port in conjunction with steep Trendelenburg. Two out of 15 patients in the gasless group were converted to pneumoperitoneum as a result of poor visualization because of inadequate anterior abdominal wall retraction in the presence of obesity.

Two randomized prospective trials evaluating the performance of the Laparolift device versus conventional laparoscopy employing CO<sub>2</sub> insufflation have recently been reported. Both studies confirmed our findings; the significant conclusion in each study was that of less-than-optimal visualization in a gasless environment.<sup>29,30</sup> Johnson and Sibert recruited a sample of 18 patients undergoing laparoscopic tubal ligation.<sup>29</sup> Four out of 10 gasless patients required conversion to pneumoperitoneum; poor visualization with concern of thermal damage to the viscera was cited as a reason for failure. Goldberg and Maurer recruited a total of 57 patients from an infertility population, with 6 out of 28 gasless cases requiring conversion to pneumoperitoneum as a result of poor exposure.<sup>30</sup>

Because of the mechanism of the Laparolift in achieving abdominal wall elevation, in which a preponderance of superior traction is created, distention of the lateral walls allowing bowel to fill the paracolic gutters does not readily occur. Therefore, visualization of the pelvis in CO<sub>2</sub> patients is more easily

obtained through a pneumoperitoneum that affords a greater degree of lateral abdominal wall distention with resultant bowel displacement. In addition, the surgeon enjoys better visualization in those procedures with pneumoperitoneum because increased intraabdominal pressure not only offers uniform distention of the abdominal wall but also compresses otherwise prominent viscera, better exposing abdominal and pelvic peritoneal surfaces.

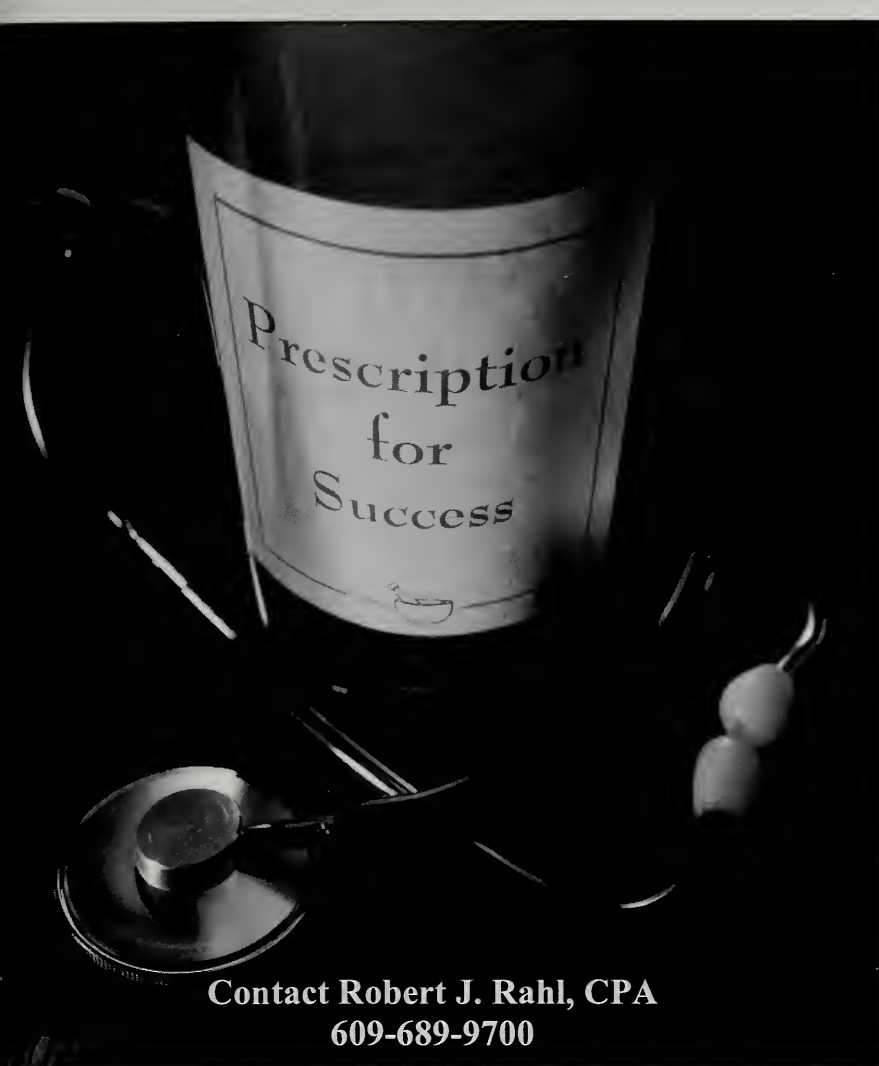
In our study, conventional laparoscopy employing CO<sub>2</sub> pneumoperitoneum was found to be preferable to gasless laparoscopy employing the Laparolift device in the performance of gynecologic surgical procedures, as it provided a more reliable visualization of the abdominopelvic cavity and was associated with less immediate postoperative discomfort. The relative increase in ET-CO<sub>2</sub> and comparative hypothermia encountered in those exposed to CO<sub>2</sub> insufflation was of little clinical significance in our population of young, healthy patients.

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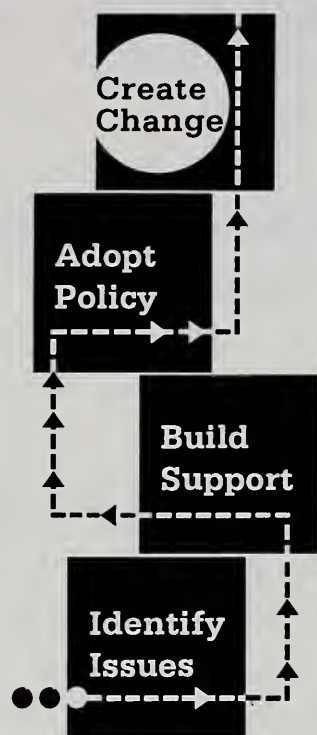
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# PREVENTION AND EARLY DIAGNOSIS OF CUTANEOUS MELANOMA

*James S. Goydos, MD*

**T**he recent rapid rise in the incidence of melanoma has necessitated an equally rapid increase in research and training to help the medical community cope with this epidemic. Only 10 to 15 years ago cutaneous melanoma was considered a relatively rare disease that had little impact on the lives of the average US citizen. The typical surgical or medical resident, outside a handful of referral centers, would see few if any patients with melanoma and received little formal training in the care of these patients. The rapid rise in incidence of melanoma in this country, however, has changed that. The increase continued at a brisk 4%-to-6%-per-year rate during the early part of the 1990s. Then, in 1996, an astonishing 12% increase in the incidence of melanoma was reported—the fastest increase in incidence of any cancer in that decade. Today, approximately one American dies of melanoma every hour and 41,600 US patients are expected to be diagnosed with melanoma this year, which will result in between 7,000 and 9,000 deaths.<sup>1</sup> Patient education, physician training, and recent advances in the

prevention, diagnosis, staging, and treatment of cutaneous melanoma have kept the death rate from rising as rapidly as the incidence. Much still needs to be done, however, to slow the increase in incidence of melanoma.

## PREVENTION

Preventing a cancer from occurring entails first determining what factors led to its occurrence. Genetic factors and sun exposure seem to be the most important determinants of melanoma risk.<sup>1,2</sup> Since we cannot yet alter our genetic makeup, we need to focus on reducing sun exposure or, more precisely, exposure to ultraviolet radiation.

## The Dangers of UV Radiation

The sun emits two types of ultraviolet (UV) light: UVA, with wavelengths between 320 nm and 420 nm, and UVB, with wavelengths between 290 nm and 320 nm. Exposure to UVB and, to a lesser extent, UVA radiation has been linked to skin cancer, immune suppression, cataracts, and other health problems.<sup>1-3</sup> There is ample evidence to suggest that nonmelanotic skin cancers are related to lifetime exposure to UVB radiation, but no

link has been found between total lifetime UVB exposure and melanoma risk. Melanoma risk appears to be related to severe episodic UVB exposure resulting in sunburns.<sup>3,4</sup> This has led the tanning industry to claim that maintaining a tan all year round, either by artificial means such as tanning booths or through the use of topical tanning products, can reduce the risk of melanoma. No evidence exists, however, that indicates that tanning protects against the development of melanoma, and other adverse health effects, such as premature skin aging, other skin cancers, cataracts, and immune suppression must be taken into account.<sup>3-5</sup> Furthermore, tanning beds are often used as preparation for intense sun exposure on vacations and thus act as ultraviolet radiation multipliers: people who would otherwise be more cautious allow themselves more sun exposure, thinking that the tanning bed has provided protection.<sup>6</sup> Tanning beds commonly use UVA radiation to induce tans, and there is evidence that tans induced by UVA are less protective against the subsequent development of sunburn. Surveys have also shown that burning



in the tanning parlor is quite common, which would also negate any protective effect.

## Sunscreens

Sunscreens have been used to decrease the chance of sunburning, and recent improvements in formulations have increased their effectiveness. Recent reports, however, have called into question the ability of sunscreens to provide protection from the development of skin cancer.<sup>4,7</sup> Data suggests that sunscreens can protect against the development of actinic keratoses, which are considered precursors of squamous cell carcinoma, but there is no conclusive experimental evidence that sunscreens protect against the development of basal cell carcinoma or melanoma.<sup>8</sup> Some studies even suggest that the use of sunscreens may increase the risk of melanoma.<sup>7-9</sup> Evidence in these studies is based on patient responses to survey questions, however, and does not take into account many confounding factors. People who use sunscreens on a regular basis may be doing so because of past severe burns or may have more sun-sensitive skin than people who do not regularly use sunscreens. Respondents to current surveys probably used less effective sunscreens in their youth, and it is unlikely that they used sunscreens in infancy.<sup>4</sup> No conclusive evidence exists that sunscreen use increases the risk of melanoma.<sup>9</sup> Because of

the long latency period between sun exposure and melanoma development, it will probably be many years before we resolve this debate. In the meantime, it is prudent to avoid sunburning by the use of sunscreens with a solar protection factor (SPF) of at least 15. People should also minimize sun exposure during the peak UVB hours (10:00 AM to 2:00 PM) and wear sunglasses, tightly woven fabrics, and wide-brimmed hats when prolonged sun exposure is unavoidable.

## Public Education

Public and professional education programs are under way that aim to decrease the incidence of chronic sun exposure in children and adolescents.<sup>1,4,10</sup> Public service messages on radio and television, poster campaigns, school-based curricula, and peer counseling have been imple-

mented in many states. The American Cancer Society, the American Academy of Dermatology, and the Skin Phototrauma Foundation have been in the forefront in developing these campaigns, targeting the populations most likely to benefit from sun protection.<sup>11</sup> Professional interventions include training programs for pediatricians, family practitioners, and other primary care physicians. Pediatricians are being encouraged to include sun protection in the list of routinely recommended injury-prevention guidelines, and patient-information materials are available from many sources. On a societal level, changes have been made to recreation facilities to include shaded areas; education programs have been implemented for lifeguards, recreation facility staff, and park rangers; free sunscreens have been distributed; and work and sport schedules have been rearranged to avoid the peak solar radiation hours. These are a few of the interventions that protect the public from the sun and change public attitudes toward tanning and sunbathing. Many of these programs have been tried on a small scale, and the data shows that these changes translate into less sun exposure, less deliberate sunbathing, and fewer sunburns in children, adolescents, and adults. The Centers for Disease Control and Prevention (CDC) is

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funding expanded programs in such states as California, Arizona, Georgia, Hawaii, and Massachusetts. We are gradually seeing a change in society's attitude toward tanning, with fewer people sunbathing on a regular basis and fewer respondents to surveys stating that a tan looks healthy.<sup>4,10,12</sup> It is hoped this trend will continue.

### Environmental Factors

At the international level, programs to decrease the depletion of the ozone layer are under way. Stratospheric ozone depletion has been linked to increased UVB radiation reaching the earth and this may be adding to skin cancer risk. Chlorofluorocarbons (CFCs) have been implicated in ozone depletion, and more than 50 countries have ratified the Montreal Protocol, which calls for a 50% reduction in CFCs by this year.<sup>3</sup> Manufacturers have begun replacing CFCs in their products, and many organizations, countries, and firms are completely phasing out their use.

### EARLY DETECTION

#### Public Screening Programs

If melanoma does occur, the best chance for cure is early detection and proper surgical care. Since melanoma usually presents as a pigmented lesion on the skin surface, early detection should not be difficult. Mass screening programs have been tried in high-incidence areas with mixed results.<sup>12,13</sup> One problem

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MELANOMA RISK.

with mass screening is that the people most likely to come to a public skin-screening or employer-sponsored clinic are those who already suspect that they have a high likelihood of developing melanoma (e.g., family history, frequent sunburns, previous skin cancer). These people often go to private physicians or local dermatologists if skin screenings are not available, and so few new patients are added to the surveillance rolls. The main target of mass public skin screenings should be those who have no idea that they may be at risk for skin cancer and may engage in high-risk activities such as sunbathing and using tanning booths. The elderly also tend to benefit from local skin screenings, and many are conducted in senior centers and nursing

homes. Another problem with mass screening programs is patient compliance. Patients told that they have a high-risk lesion on their skin or who are instructed in sun avoidance behaviors rarely follow through with follow-up care. To combat this problem, many screening programs incorporate dermatology listings, appointment assistance, and family counseling. The Cancer Institute of New Jersey and its affiliate network of hospitals offer public screening programs in many locations around the state.

### Self-Examination

Self-examinations and skin screening during routine physical exams have been shown to be more effective in detecting skin cancer than mass screening, although problems also exist with this screening method.<sup>12,14</sup> Many physicians are not comfortable with the identification of early melanomas, and teaching patients is time-consuming and expensive. Physician and patient education programs are under way in many states, and residency programs in many specialties now include skin tumors in their curriculum. Furthermore, the National Cancer Institute, the American Academy of Dermatology, and the American Cancer Society all offer resource material to the public and to interested physicians. Color pamphlets, self-examination instructions, and a glossary to help



with definitions are usually welcomed by patients and are often passed on to friends and family members, reaching people who may not seek medical advice on their own.

## CONCLUSION

A paradigm shift has taken place in the prevention and early diagnosis of melanoma. A better understanding of the causes of melanoma and other skin cancers has led to efforts aimed at prevention, including public-awareness programs, better sunscreens, and environmental interventions. Mass screenings continue in high-risk areas of the country, and public service advertisement campaigns are under way to increase the public's concern about this preventable and often deadly disease. Physician education should lead to better individual screening exams, and a close examination of the skin is becoming a routine part of every physical examination. With these interventions we should begin to see a drop in the incidence of this once-rare disease.

James S. Goydos is assistant professor, department of surgery and director of the melanoma and sarcoma program at UMDNJ-Robert Wood Johnson Medical School. He is a member of the Cancer Institute of New Jersey.

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# ACCOUNTS RECEIVABLE SYSTEMS: THE KEY TO FINANCIAL HEALTH

JUST AS MEDICAL TECHNOLOGY HAS MADE QUANTUM LEAPS DURING THE PAST FEW DECADES, THE BUSINESS SIDE OF RUNNING AND MAINTAINING A MEDICAL PRACTICE HAS CHANGED DRAMATICALLY AS WELL. GONE ARE THE DAYS WHEN PHYSICIANS COULD SUBMIT BILLS TO INSURANCE COMPANIES AND EXPECT TO RECEIVE TIMELY PAYMENT. EVEN LONGER GONE ARE THE DAYS WHEN PATIENTS WALKED INTO A DOCTOR'S OFFICE ACTUALLY PREPARED TO WRITE A CHECK OR LEAVE CASH FOR SERVICES. TODAY, THE TASK OF BILLING AND COLLECTING IS MORE COMPLEX, MORE TIME CONSUMING, AND MORE DESERVING OF THE ATTENTION OF A SKILLED OFFICE WORKER.

*Barbara Peterson*

**M**ost physicians today are faced with rising practice overhead and declining practice revenue. In this environment, it may seem difficult to justify the salary of a highly skilled employee to perform billing or the fees for an outside billing service. However, without close attention to billing and collection, doctors will certainly fail to maximize the main source of their practice income—revenues from patient visits.

## **Reimbursements Down— Payment Lags Up**

Managed care is gradually becoming the dominant payor for physician practices. In general, managed care organizations rely on Medicare

and Medicaid rates as benchmarks for setting reimbursement. No one realistically expects reimbursement levels to increase. Fees for services rendered are down. In addition, many insurers delay payments to providers for as long as contractually possible, throwing up such obstacles to the payment process as pending claims for review or returning claims for additional information. The insurer accrues interest on the money that is not forwarded promptly to the physician. The insurer is testing the limits of the medical staff's ability to stick to a collection policy with such roadblocks. Many physician practices fail to diligently pursue payments due them simply because there is no

time or established protocol to do so.

## **What Can a Practice Do?**

Billing and collections should be thought of as a specialized service to be performed by a trained professional. To maximize returns, the practice should have dedicated billing personnel who concentrate solely on this task. Depending on the size of the practice, this could range from a regular part-time office worker to a team of billers, each focused on different areas, or payors, and supervised by a billing manager. No matter how large or small, the staff should have clearly articulated performance standards, written job descriptions, and close supervision.



Ideally, the billing staff should form relationships with employees at the practice's major payors. This is not a frivolous use of time. It gives the staff a direct line to the payor to more easily ask questions and settle disputes. It also provides an inroad to reinforce to payors that the office is monitoring unnecessary payment delays and may pursue legal action for unfair tactics or failure to pay interest on late claims (if contractually mandated). Finally, as capitation payments (for all specialties) become more prevalent, having established relationships between the staff and payors will allow for better, more informed, management of capitated contracts and for opportunities to negotiate lump-sum payments and other creative solutions to problems.

### **How is Employee Performance Monitored?**

Most physicians are not accountants and would not enjoy reviewing thoroughly the complexities of billing trends, regulations, and payor requirements. But they can make sure that their staff possesses this knowledge. At a minimum, the staff should:

- File claims electronically, whenever possible.
- Process clean claims within 24 to 48 hours of service.
- Reprocess any denials or rejections within 24 hours of receipt.
- Aggressively pursue any claim that is more than 45 days old.

To effectively monitor staff performance, the physician should ask them for a monthly (or weekly) performance report for accounts receivable (A/R). Over time, this report can be used to monitor not only A/R but also employee performance. This report should include a tally for number of calls made per day to carriers, total number of clean claims processed per day, and number of reprocesses attempted per day. There should also be a calculation of submission error rates (percentage of claims submitted that are rejected). If possible, the error rate should be broken out by major payors.

After collecting a few months of management reports, the physician will be able to track and evaluate employee performance, perform trend analysis, adjust for seasonal (or personnel) fluctuations, and construct a clear picture of any problems with A/R.

### **What Does a Healthy A/R Program Look Like?**

Even the strongest A/R program is not 100% complete and effective. There are, however, some baseline standards. In general, the practice should employ trained and qualified billing personnel. This individual (or team) should be dedicated to A/R functions and not responsible for other clinical or nonclinical duties. Written policies and procedures should be in place describing how billing is to be performed and

defining benchmarks for staff performance (e.g., number of calls made per day to carriers, total number of clean claims processed per day, number of reprocesses attempted per day, and submission error rate). If the practice does not currently have established performance standards, it can set them after a few months of the staff collecting the data.

Overall, the characteristics of an effective A/R program are:

- Clean claims are processed in 24 to 48 hours.
- The net collection rate is 80% to 90%.
- Active A/R charges are less than three months old.
- The dollar value of charges more than 90 days old does not exceed the dollar value of current charges (excluding those delinquent accounts designated to be turned over to a collection agency).
- The adjustment rate does not exceed 35% to 40% of gross charges.
- Claim rejection rate is less than 10%.
- The staff does not continue to pursue claims that they are fairly certain will never be settled—they use their valuable time to work realistic accounts.

### **Setting Up a Successful Billing and Collection Department**

Many physicians have inherited office management techniques from

former colleagues. Setting up a successful business takes time and skill. These are not acceptable excuses for ignoring existing or emergent problems. Once the practice has established a strong and functional foundation for the billing and collection department, the framework need not be revisited on a regular basis, although the process should be reviewed from time to time to ensure optimal performance. Hiring skilled personnel can save time in performing daily functions and can maximize revenue collection. If hiring skilled personnel is not an option, the physician needs to take a critical look at the current (or inherited) billing structure and function to ensure that there is an effective and efficient A/R management process in place. Here are some fundamental elements in the process.

**Organizing the Practice's Payors.** A current list of all managed care contracts and a listing of all approved referral providers (e.g., lab, radiology, etc.) should be drawn up and kept at the front desk and billing office. (Often, medical offices have this information in several places.) The simplest method to keep it accessible and up to date is the old-fashioned way—with a three-ring binder, organized by managed care company. The ringed-binder system makes it easy to make changes.

Care must be taken with referral forms. Subject of course to medical judgment, the physician must not

provide services, referrals, or durable medical equipment for nonemergency services without proper referral forms. Failure to follow payor protocols will result in payment refusal.

The staff must keep a critical eye on payor reimbursements and review payments that are too low for the amount of the billed charges to determine whether there are errors. Payments should be compared with the contractually agreed on rates. Everyone makes mistakes. The practice should try to renegotiate more favorable rates—it can be done, especially if the staff has established relationships with the payors.

The staff should create an outpatient and inpatient tracking system to monitor whether all services provided have been accounted for and are able to be billed. The system must conform to the requirements of the practice's payors.

**At the Time of Patient Visit.** The staff should run the practice with a fee-for-service attitude. The physician must establish policies and procedures that are consistently followed with each patient. In the long run, this reduces errors and will help eliminate misunderstandings.

The staff should place a photocopy of the patient's insurance card(s) in the chart. The staff should also double-check patient demographic and insurance information at patient check-in and make any changes immediately. All patients

should be informed that payment is required at time of service, unless other arrangements are specifically approved by the office. This simply means that patients must indicate insurance or managed care carrier up front or agree to pay themselves. This provides the opportunity to inform patients about which carriers the practice participates with and establishes the fact that the patient will be responsible for payment if his or her managed care plan is not accepted.

The practice should establish a policy of collecting copays and prior balances at check-in. When calling to confirm patient appointments, the practice should inform the patient of any prior balance due and the practice's expectations for payment. Private discussion about payment arrangements should be offered.

The staff should ensure that there is a superbill (or encounter form) for each patient visit. This should contain the correct CPT and ICD codes, along with any appropriate billing modifiers and physician or clinician signature.

**A/R and Patients.** This article has discussed some methods for improving communications with insurance carriers and managed care organizations. However, there is another payor in the medical practice—the patient. The office should not neglect to bill patients in a straightforward and professional



manner. Here are some tips for creating a service standard for patient billing:

- Reconcile refunds for the month before releasing patient statements.
- Send patient statements on a rotational basis monthly.
- Segment the A/R system to run a specific section of the alphabet weekly, more evenly dispersing the work and revenue flow.
- Do not inflate the A/R report with unrealistically high patient charges.
- Perform write-offs in a timely fashion.
- Routinely and consistently identify accounts to be sent to a collection agency.
- Segregate delinquent accounts from the current A/R accounts when possible, to create an uninflated A/R.
- Before the close of the fiscal year, review all accounts more than 90 days old. Resubmit when possible or perform appropriate write-offs on selected accounts so that the A/R report is as clean as possible.
- Do not continue to pursue claims that seem fairly certain will never be settled.

### Important Annual Reviews

To maximize reimbursements, the physician must keep an eye on how payments are being requested. Each year, the practice should review CPT and ICD codes and its fee schedule for changes or modifications. Two

areas need to be evaluated. First, the codes need to be reviewed to confirm that they are reflective of the current year's mandates. Should codes be eliminated, or are added codes needed for new procedures? Second, have individual carriers adopted any new codes or modifiers that replace the existing codes? Superbills must be changed if warranted. The medical staff should be careful; coding errors can be costly. Incorrect coding may cause the practice to lose deserved revenue; on the other hand, "up-coding" or "overcoding" and unbundling a procedure can be construed as fraud. Both situations should be avoided. Fraud-and-abuse audits of physician practices are becoming more commonplace. Heavy fines, loss of participation in contracts, and legal action are just some of the penalties that may be levied. The practice's employees must be made aware of the dangers of fraud and abuse charges.

With the managed care contract list (the notebook mentioned previously or the carrier's fee schedule loaded into the computer system), it will be simple to take the time to review the current payments from each carrier and make sure that they match the contractual fee. The practice should strongly consider renegotiating contracts or terminating any contracts that are not financially successful.

### A Final Word

Establishment of a structured billing and collection management,

or A/R, function will require some effort on the physician's part. The benefits of doing so, however, far exceed that effort. They include maximizing practice revenue, standardizing employee performance, establishing potentially valuable relationships with payors, clearly articulating payment policies for patients, and reducing exposure to charges of fraud and abuse.

Use, review, and analysis of monthly A/R reports can help a practice to flourish. These tools can be used to monitor not only the fiscal health of the practice but also performance of the employees that have been assigned to the tasks of billing and collections. After a few months of data collection, the practice will be able to do the following:

- Identify key issues that delay reimbursement, such as specific procedures or payor groups.
- Create an early warning system for weaknesses in billing operations.
- Monitor payor base percentages and referral sources.
- Track procedures performed and payor reimbursement.
- Monitor physician, employee, and practice productivity.
- Monitor financial success of specific procedures or practice interests.

*Barbara Peterson is a senior consultant at MIIX HEALTHCARE Group, Lawrenceville NJ.*



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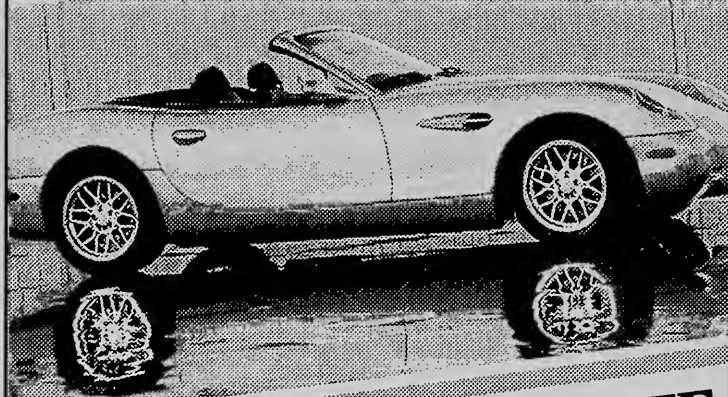
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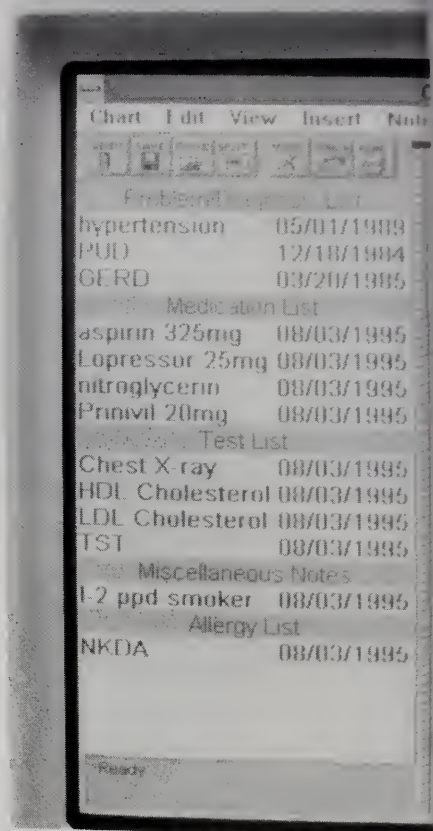
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Ralph Burton Maffey, MD, Kearny  
David Miller, MD, Homosassa, Florida  
Silverio Quaglia, MD, West Palm Beach, Florida  
Morton H. Rachelson, MD, Boca Raton, Florida  
Louis J. Sanfilippo, MD, Short Hills  
Berthold Eric Schwarz, MD, Vero Beach, Florida  
Michael H. Scoppetuolo, MD, Belleville  
John F. Vining, MD, Greenville, South Carolina  
William Edward Wagner, Jr., MD, Basking Ridge  
Mary McNeal Wood, MD, Montclair  
Francis A. Wood, MD, Montclair  
Jordan Z. Zwetkoff, MD, West Orange

## HUDSON COUNTY

Margaret R. Beke, MD, North Plainfield  
Nellie Louise Mitchell, MD, Rochester, New York

## MERCER COUNTY

Albert Davne, MD, Boca Raton, Florida  
Thomas J. Dougherty, MD, Yardley, Pennsylvania  
Zenon Gill, MD, Depew, New York  
Julius J. Hafitz, MD, Titusville  
Arthur Krosnick, MD, Princeton  
Aris M. Sophocles, MD, Yardville  
Alfred Johann Strauss, MD, Princeton

## MIDDLESEX COUNTY

Sara Ann Bunin, MD, Perth Amboy  
Vincent Julius Cannamela, MD, Metuchen  
Arthur L. Roth, MD, Boca Raton, Florida  
Samuel Sklar, MD, Highland Park

## MONMOUTH COUNTY

Forman T. Bailey, Jr., MD, Ocean Grove  
Alfred J. Casagrande, MD, Matawan  
Stanley Edeiken, MD, Highland Beach, Florida  
Julio Tomas Noguera, MD, Interlaken  
Urie Allen Parkhill, MD, Spring Lake  
John Fisk Stockfisch, MD, Ocean  
Genevieve June Thomas, MD, Manaken Sabot, Virginia  
James Andrew Weldon, MD, Holmdel

George Traver Whittle, MD, Stuart, Florida

## MORRIS COUNTY

Charles H. Bippart, MD, Morristown  
Martin J. Crotty, MD, Denville  
Dominick Joseph Huster, MD, Morris Plains  
Jaroslav J. Lenko, MD, Boonton  
Raymond Charles Maronpot, MD, Jupiter, Florida  
Domenico Miranda, MD, Whippany  
David J. Reisner, MD, Weybridge, Vermont

## OCEAN COUNTY

Eli A. Baruch, MD, Toms River  
Humbert Michael Gambacorta, MD, Toms River  
Jo Anne Overleese, MD, La Jolla, California

## PASSAIC COUNTY

Dimitrios J. Fotiadis, MD, Clifton  
Won Bong Hahn, MD, Pittstown  
Jose D. Perez, MD, Clifton  
Salvatore Sapienza, MD, Wayne

## SOMERSET COUNTY

Dirk Enthoven, MD, FACG, Bernardsville  
Joseph James Phillips, MD, Bridgewater

## UNION COUNTY

Jean Abel Cramer, MD, Flemington  
Harrison Fertig, MD, Plainfield  
Milton David Fox, MD, Mountainside  
Eugene Chamberlin Hohenstein, MD, Westfield  
Alexander Daniel Kovacs, MD, Sun City, Arizona  
Arthur Sayre Mc Lellan, MD, Chester  
Albert Minzter, MD, Westfield  
Arthur Perell, MD, Vero Beach, Florida  
Emil Gerald Piserchia, MD, Summit  
Charles R. Ream, MD, Princeton  
Maximillian Schoss, MD, Westfield  
Raymond Lawrence Stone, MD, Elizabeth

## WARREN COUNTY

Nathan I. Kantor, MD, Melbourne, Florida  
Ih Chin Kim, MD, Phillipsburg



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# DIRECTORY OF NEW JERSEY TOBACCO-FREE PHARMACIES

The following is a list of pharmacies in New Jersey that do not sell tobacco. The list was compiled by Vernon R. Daly, MD, and is also posted on his Web site at [www.heurekacenter.org](http://www.heurekacenter.org).

## ATLANTIC COUNTY

### Atlantic City

Parkway Pharmacy  
2838 Atlantic Avenue  
Atlantic City NJ 08401-6326  
(609) 345-5105

## BERGEN COUNTY

### Closter

Morse's Pharmacy Inc.  
226 Closter Dock Road  
Closter NJ 07624-1905  
(201) 768-1368

### Elmwood Park

Elmwood Drugs  
73 Broadway  
Elmwood Park NJ 07407-3007  
(201) 796-0400

### Fort Lee

Medicine Shoppe  
3468 Lemoine Avenue  
Fort Lee NJ 07024  
(201) 944-1002

Randy's Rx & Surgical Inc.  
810 Abbott Boulevard  
Fort Lee NJ 07024-4116  
(201) 224-4700

### Glen Rock

Rock Ridge Pharmacy  
191 Rock Road  
Glen Rock NJ 07452-1706  
(201) 444-4190

Medicine Shoppe  
941 Lincoln Avenue  
Glen Rock NJ 07452  
(201) 652-9282

### Hackensack

Medicine Shoppe  
441 Passaic Street  
Hackensack NJ 07601  
(201) 488-1230

### Moonachie

Baron Drug & Surgical Inc  
91 Moonachie Road  
Moonachie NJ 07074-1016  
(201) 641-1110

### North Arlington

H-B Drugs  
155 Ridge Road  
North Arlington NJ 07031-6015  
(201) 997-2010

### Oradell

Jay's Pharmacy  
223 Kinderkamack Road  
Oradell NJ 07649-2129  
(201) 262-1800

### Paramus

Medicine Shoppe  
436 Forest Avenue  
Paramus NJ 07652  
(201) 261-4641

### Park Ridge

Ridgemont Drugs  
197 Kinderkamack Road  
Park Ridge NJ 07656-1335  
(201) 391-3232

### Ridgewood

Town & Country Pharmacy  
60 Ridgewood Avenue  
Ridgewood NJ 07450  
(201) 652-0013

### River Vale

Medicine Shoppe  
673 Westwood Avenue  
River Vale NJ 07675  
(201) 664-5553

### Saddlebrook

Medicine Shoppe  
487 Market Street  
Saddlebrook NJ 07663  
(201) 291-0844

### Wycoff

Sicomac Pharmacy  
300 Sicomac Avenue  
Wycoff NJ 07481-2132  
(201) 891-0822

## BURLINGTON COUNTY

### Browns Mills

Power's Pharmacy  
567A Lakehurst Road  
Brown Mills NJ 08015  
(609) 893-4700

### Burlington

The Medicine Shoppe  
1005 Sunset Road  
Burlington Twp. New Jersey  
(609) 386-3630

### Cinnaminson

Rosvold Pharmacy  
Route 130 N. & New Albany Road  
Cinnaminson NJ  
(609) 829-4877

### Columbus

Boyd's Pharmacy  
Suite F Homestead Plaza  
Columbus NJ 08022  
(609) 298-7474



**Florence**

Boyd's Pharmacy  
306-308 Broad Street  
Florence NJ  
(609) 499-0100

**Marlton**

Cropwell Pharmacy  
527 W. Old Marlton Pike  
Marlton NJ  
(609) 596-7305

**Meetinghouse Pharmacy**

Hainsport-Mt. Laurel & Church  
Roads  
Marlton NJ 08053  
(609) 596-1616

**Medford**

Chemist Shoppe  
666 Stokes Road  
Medford NJ  
(609) 953-0866

Nugent's Apothecary  
103 Old Marlton Pike  
Medford NJ  
(609) 654-5757

Stokes Pharmacy  
639 Stokes Road  
Medford NJ  
(609) 654-5222

**Moorestown**

Stiles Pharmacy  
75 E. Main Street  
Moorestown NJ 08057-3330  
(609) 235-0088

**New Egypt**

Hartman Pharmacy  
29 Main Street  
New Egypt NJ 08533-1415  
(609) 758-2249

**Palmyra**

Palmyra Pharmacy  
1 E. Broad Street  
Palmyra NJ 08065  
(609) 829-1597

**Pemberton**

Boyd's Pharmacy of Pemberton Inc.  
87 Hanover Street  
Pemberton NJ 07206-1131  
(609) 894-8288

**Roebling**

Roebing Pharmacy  
4th & Main Street  
Roebing NJ  
(609) 499-0159

**Tabernacle**

Alfors Pharmacy  
1572 Route 206  
Tabernacle NJ  
(609) 268-2235

**CAMDEN COUNTY****Audubon**

Medicine Shoppe  
298 S. White Horse Pike  
Audubon NJ 08106  
(609) 546-0044

**Berlin**

Professional Center Pharmacy  
Route 73  
Berlin NJ 08009  
(609) 767-6663

**Camden**

Doganieros Pharmacy Inc.  
1552 Mt. Ephraim Avenue  
Camden NJ 08104-1662  
(856) 966-4400

**Merchantville**

Towne Pharmacy  
45 South Centre Street  
Merchantville NJ 08109-2211  
(856) 665-8405

**Somerdale**

Medicine Shoppe  
20 White Horse Pike  
Unit 7  
Somerdale NJ 08083  
(609) 782-8716

**Stratford**

Sterling Pharmacy  
404 N. Whitehorse Pike  
Stratford NJ 08084-1113  
(856) 346-1122

**CAPE MAY COUNTY****Marmora**

Medicine Shoppe  
210 S. Shore Road  
Marmora NJ 08223  
(609) 390-7912

Village Pharmacy  
38 Old Tuckahoe Road  
Marmora NJ 08223  
(609) 390-9594

**CUMBERLAND COUNTY****Bridgeton**

Laurel Pharmacy  
48 South Laurel Street  
Bridgeton NJ 08302-1945  
(609) 451-2122

**Millville**

Richard H. Knowles Pharmacy  
600 N. High Street  
Millville NJ 08332  
(609) 825-0721

**ESSEX COUNTY****Belleville**

Good Health Pharmacy  
530 Joralemon Street  
Belleville NJ 07109  
(973) 759-2761

**Bloomfield**

Burgess Chemist  
56 Broad Street  
Bloomfield NJ 07003  
(973) 743-1005

**Cedar Grove**

Medicine Shoppe  
972 Pompton Avenue  
Cedar Grove NJ 07009  
(973) 239-3339

**Montclair**

Grove Pharmacy  
123 Grove Street  
Montclair NJ 07042-4021  
(973) 744-5550

**Newark**

Broadway Health Pharmacy  
57 Broad Street  
Newark NJ 07104-2503  
(973) 485-9150

Community Health Pharmacy  
644 Prospect Avenue  
Newark NJ 07104  
(973) 428-3050

Daily Need Pharmacy  
351 Avon Avenue  
Newark NJ 07108  
(973) 623-1440

Friendship Pharmacy  
212 Bloomfield Avenue  
Newark NJ 07104  
(973) 484-0643

Leo Hopp Pharmacy  
447 Orange Street  
Newark NJ 07107-2901  
(973) 482-7732

United Drugs  
526-528 Central Avenue  
Newark NJ 07107  
(973) 645-1115

Weisbrods Prescription Pharmacy  
980 South Orange Avenue  
Newark NJ 07106-1714  
(973) 371-2771

**Nutley**  
Medicine Shoppe  
559 Franklin Avenue  
Nutley NJ 07110  
(973) 235-0909

White Oak Pharmacy  
88 Union Avenue  
Nutley NJ 07110-3374  
(973) 667-1434

**Summit**  
Liss Pharmacy  
407 Springfield Avenue  
Summit NJ 07901-2603  
(973) 277-0399

## **GLOUCESTER COUNTY**

**Glassboro**  
Marone Pharmacy  
1012 E. High Street  
Glassboro NJ 08028  
(856) 881-5121

**Mullica Hill**  
Main Street Apothecary  
50 N. Main Street  
Mullica Hill NJ 08062  
(856) 478-0202

## **HUDSON COUNTY**

**Bayonne**  
Jerry's Drug & Surgical Supply  
455 Broadway  
Bayonne NJ 07002-3623  
(201) 339-1992

**Jersey City**  
Vena Pharmacy  
497 Mercer Street  
Jersey City NJ 07306-2401  
(201) 333-8034

**Union City**  
Cornell Drug  
4515 Bergenline Avenue  
Union City NJ 07087-2732  
(201) 865-3581

**Weehawken**  
Hamilton Pharmacy  
3500 Park Avenue  
Weehawken NJ 07084-6006  
(201) 864-0888

**West New York**  
Gerards Pharmacy  
5001 Bergenline Avenue  
West New York NJ 07093-5600  
(201) 863-4882

Marin Pharmacy  
5222 Bergenline Avenue  
West New York NJ 07093-5524  
(201) 866-8348

Pan American Pharmacy  
232 60th Street  
West New York NJ 07093-2824  
(201) 861-7966

Singer's Pharmacy  
5532 Bergenline Avenue  
West New York NJ 07093  
(201) 864-1168

## **HUNTERDON COUNTY**

**Clinton**  
Grayrock Pharmacy  
1802 State Route 31, Suite 6  
Clinton NJ 08809-2033  
(908) 638-4000

**Lambertville**  
Lambertville Pharmacy Inc.  
1 Cherry Street  
Lambertville NJ 08701-3343  
(609) 397-0730

## **MERCER COUNTY**

**Trenton**  
The Robbins Pharmacy  
2108 Pennington Road  
Trenton NJ 08638-1416  
(609) 882-2404

Westside Pharmacy  
215 N. Hermitage Avenue  
Trenton NJ 08618-5511  
(609) 394-0600

## **MIDDLESEX COUNTY**

**Cranbury**  
Medicine Shoppe  
337 Applegarth Road, Suite 4B  
Cranbury NJ 03512  
(609) 395-9330

**East Brunswick**  
Civic Center Pharmacy Inc.  
316 Rues Lane  
East Brunswick NJ 08816-3608  
(732) 254-3900

**New Brunswick**  
Zajac's Pharmacy  
223-225 George Street  
New Brunswick NJ 08901-1318  
(732) 545-0582

**Parlin**  
Medicine Shoppe  
3310 Washington Road  
Parlin NJ 08859  
(732) 727-0993

**South Amboy**  
Madura Pharmacy  
115 N. Broadway  
South Amboy NJ 08879-1660  
(732) 721-1732

**South Plainfield**  
Medicine Shoppe  
144 Maple Avenue  
South Plainfield NJ 07080  
(908) 754-0707



Twin City Pharmacy  
1710 Park Avenue  
South Plainfield NJ 07080  
(908) 755-7696

**Woodbridge**  
Medicine Shoppe  
435 Amboy Avenue  
Woodbridge NJ 07095  
(732) 636-0011

## MONMOUTH COUNTY

**Allentown**  
The Globus Pharmacy  
1280 Yardville Road  
Allentown NJ 08501  
(609) 259-2202

Walters Pharmacy  
2 South Main Street  
Allentown NJ 08501-1603  
(609) 259-6121

**Englishtown**  
Maio's Medicine Chest Inc.  
345 Union Hill Road  
Englishtown NJ 07726-1864  
(732) 536-4705

**Freehold**  
Freehold Boro Pharmacy  
(R & M Pharmacy Inc.)  
31 East Main Street  
Freehold NJ 07728  
(732) 761-1234

**Hazlet**  
Medicine Shoppe  
3253 Highway 35  
Hazlet NJ 07730  
(732) 888-7900

**Rumson**  
Rumson Pharmacy  
22 W. River Road  
Rumson NJ 07760-1419  
(732) 842-1234

**Sea Girt**  
Campbell Pharmacy  
2175 Highway 35  
Sea Girt NJ 08750  
(732) 974-2929

## MORRIS COUNTY

**Boonton**  
Boonton Pharmacy Inc.  
600 Myrtle Avenue  
Boonton NJ 07005-1915  
(973) 334-4444

**Budd Lake**  
Lakeview Drug & Surgical  
Route 46 Lakeview Plaza  
Budd Lake NJ 07828-1505  
(973) 691-1117

**Denville**  
Gerards Pharmacy  
9 Broadway  
Denville NJ 07834-2703  
(973) 627-0187

**East Hanover**  
Medicine Shoppe  
434 Ridgedale Avenue  
East Hanover NJ 07936  
(973) 781-9877

**Flanders**  
Pink's Pharmacy  
293 Route 206  
Sutton Park  
Flanders NJ 07836  
(973) 584-1900

Molnar Pharmacy  
76 Morris Street  
Morristown NJ 07960  
(973) 538-5053

**Netcong**  
Netcong Pharmacy  
17 Maple Avenue  
Netcong NJ 07857-0635  
(973) 347-0067

**Rockaway**  
Medicine Shoppe  
25 West Main Street  
Rockaway NJ 07866  
(973) 625-8558

**Stirling**  
Dorsi's Pharmacy  
184 Central Avenue  
Stirling NJ 07980-1233  
(908) 647-7878

## OCEAN COUNTY

**Forked River**  
Medicine Shoppe  
528 West Lacey Road  
Forked River NJ 08721  
(609) 242-1400

**Lakewood**  
King's Pharmacy  
251 Second Street  
Lakewood NJ 08701-3343  
(732) 364-7302

Medicine Shoppe  
681 River Avenue  
Lakewood NJ 08701  
(732) 367-5080

**Tom's River**  
Medicine Shoppe  
226 Route 37 West  
Unit 6  
Toms River NJ 08755  
(732) 341-8484

Rands Professional Pharmacy  
1843 Hooper Avenue  
Toms River NJ 08753-8128  
(723) 255-3211

**Whiting**  
Medicine Shoppe  
63-I Lacey Road  
Whiting NJ 08759  
(732) 350-4535

## PASSAIC COUNTY

**Bloomington**  
Medicine Shoppe  
36-A Main Street  
Bloomington NJ 07403  
(973) 838-0909

**Clifton**  
Medicine Shoppe  
595 Van Houten Avenue  
Clifton NJ 07013

Middle Village Pharmacy  
393 Piaget Avenue  
Clifton NJ 07011-3001  
(973) 478-0600

**Passaic**

Lawrence Drugs Inc.  
580 Broadway  
Passaic NJ 07055-1954  
(973) 777-7740

**Paterson**

Paterson Pharmacy Inc.  
430 Madison Avenue  
Paterson NJ 07524-2728  
(973) 278-5808

**Williams Pharmacy**

305 Broadway  
Paterson NJ 07501-2102  
(973) 523-0777

**Totowa**

Olsten Health Services (Pharmacy)  
11-B Commerce Way  
Totowa NJ 07512  
(973) 256-1870

**Wanaque**

Shippee's Pharmacy Inc.  
636 Ringwood Avenue  
Wanaque NJ 07465-2016  
(973) 835-6871

**Wayne**

Preakness Pharmacy  
1 Preakness Shopping Center  
Wayne NJ 07470-5057  
(973) 694-2404

**SALEM COUNTY****Woodstown**

Woodstown Pharmacy  
9 North Main Street  
Woodstown NJ 08098  
(609) 769-4100

**SOMERSET COUNTY****Bound Brook**

Union Avenue Pharmacy Inc.  
433 W. Union Avenue  
Bound Brook NJ 08805-1220  
(732) 356-3113

**Piscataway**

Busch/Livingston Pharmacy  
Hospital Road & Avenue E  
Piscataway NJ 08854  
(732) 463-8488

**Somerset**

Medicine Shoppe  
500 Hamilton Street  
Somerset NJ 08873  
(732) 247-3363

**Somerville**

Hillsboro Pharmacy  
438 Route 206 South  
Somerville NJ 08876  
(908) 359-3121

**Warren**

Edgewood Pharmacy  
62 Mountain Boulevard  
Warren NJ 07060-6331  
(908) 754-4400

**SUSSEX COUNTY****Andover**

Medicine Shoppe  
146 Route 206  
Andover NJ 07821  
(973) 786-5300

**Branchville**

Family Drug Shops  
19 Main Street  
Branchville NJ 07826-5526  
(973) 948-3170

**Hopatcong**

Medicine Shoppe  
50 Hopatchung Road  
Hopatcong NJ 07843  
(973) 398-6066

**UNION COUNTY****Cranford**

Cranford Pharmacy  
109 South Avenue E  
Cranford NJ 07016-2661  
(908) 276-0141

Cranford Plaza Pharmacy Inc.  
123 North Union Avenue  
Cranford NJ 07016-2173  
(908) 272-8811

**Elizabeth**

Camachio Pharmacy  
509 Elizabeth Avenue  
Elizabeth NJ 07206-1130  
(908) 355-1784

**Plainfield**

Rapp's Pharmacy  
611 Park Avenue  
Plainfield NJ 07060-1612  
(908) 756-0008

**Union**

Nawrocki's Pharmacy  
1214 Stuyvesant Avenue  
Union NJ 07083-3822  
(908) 688-8048

**Westfield**

Tiffany Drugs Inc.  
1115 South Avenue West  
Westfield NJ 07090  
(908) 233-2200

**WARREN COUNTY****Alpha**

Alpha Pharmacy  
1596 Third Avenue  
Alpha NJ 08865-4608  
(908) 454-4362

**Blairstown**

North Warren Pharmacy & Gifts  
155 US Route 94  
Blairstown NJ 07825  
(908) 362-5156

**Phillipsburg**

Reynolds Pharmacy  
413 South Main Street  
Phillipsburg NJ 08865-3018  
(908) 454-0541

To obtain additional copies of the  
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| • <i>General Surgeons</i>    | <i>\$18,453</i> | • <i>Dermatologists</i>      | <i>\$ 4,952</i> |
| • <i>Internists</i>          | <i>\$ 5,331</i> | • <i>Psychiatrists w/ect</i> | <i>\$ 2,937</i> |
| • <i>Gastroenterologists</i> | <i>\$ 3,554</i> | • <i>Urologists</i>          | <i>\$11,993</i> |

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<sup>1</sup>Underwriting approval required. <sup>2</sup>May need groups of 3 or more depending on specialty.

## PEOPLE IN THE NEWS

**Dale Berkley, DPM**, was recently elected chief of podiatry, department of surgery, at Capital Health System. She has been a member of the Capital Health System medical staff since 1985.

**Kirk P. Kalemkeris,**

**MD**, has been selected by the National Ethnic Coalition of Organizations as a 2000 Ellis Island Medal of Honor recipient for his humanitarian efforts and contributions to the country.

MasterCare Companies, Inc., has chosen **Scott F. Nadler, DO**; **Arthur Vasen, MD, PhD**; and **Michael L. Silverstein, MD**, as its Platinum Doctors of the Year because of their dedication to providing patients with unsurpassed medical care while working to ensure that employees get back to work as quickly as possible.

**Carolyn E. Bekes, MD**, has been named executive vice president/medical affairs at the Cooper Health System, responsible for medical staff development and undergraduate and continuing medical

education. In addition to her responsibilities as an attending physician in the departments of anesthesia and medicine, division of pulmonary and critical care medicine, she is the hospital's chief compliance officer.

**Larry W. Cohen, DO**, has been appointed to a three-year term on the board of trustees of Kennedy Memorial Hospitals-University Medical Center.

## SENIORS WHO NEED HEALTH CARE MOST CAN AFFORD IT LEAST

According to a new Rutgers study published in the *Journal of Gerontology: Social Sciences*, senior citizens who need health care the most can least afford it. Elderly Americans spend on average 19% of the total income on out-of-pocket medical expenses annually; more than half these payments go toward prescription drugs

and dental care. Those in the lowest-fifth income level spend 32% of their income, despite Medicaid coverage for some. Prescribed medication costs have grown to account for 33.9% of overall out-of-pocket payments by senior citizens to health care providers.

## PHILADELPHIA-AREA EMPHYSEMA PATIENTS MAY BE ELIGIBLE FOR NATIONAL TRIAL

Physicians at Temple University Hospital and the University of Pennsylvania Medical Center are participating in the National Emphysema Treatment Trial (NETT) to determine whether lung-volume-reduction surgery has a role in the treatment of patients with emphysema. The study will enroll a

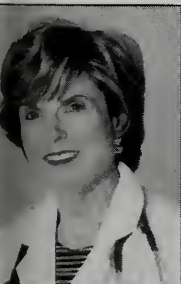
total of 2,500 emphysema patients. All NETT patients will receive 6 to 10 weeks of medical treatment and may then be randomly assigned to either surgery with medical treatment or medical treatment alone. For more information, call (800) 314-2597 or visit [www.EmphysemaStudy.org](http://www.EmphysemaStudy.org).

## ASPIRIN GREATLY UNDERUSED BY PEOPLE WITH HEART DISEASE

Only 26% of people with heart disease who could have benefited from aspirin therapy took aspirin, according to a recent study. Physicians may not be paying adequate attention to this prevention strategy. The American Heart Association has developed a patient brochure and a professional's tool kit to help increase awareness among health care providers and patients. The tool kit is designed for distribution to health care providers to use in educating or counseling patients in the primary or secondary prevention audiences. To order either the tool kit or the patient booklet, send a fax to the attention of "Knock Out America's Hidden Health Threat" to (214) 706-5233 or call (800) 242-8721. Materials for physicians and other health care professionals are also available at [www.americanheart.org](http://www.americanheart.org).



Dale Berkley, DPM



Carolyn E. Bekes, MD



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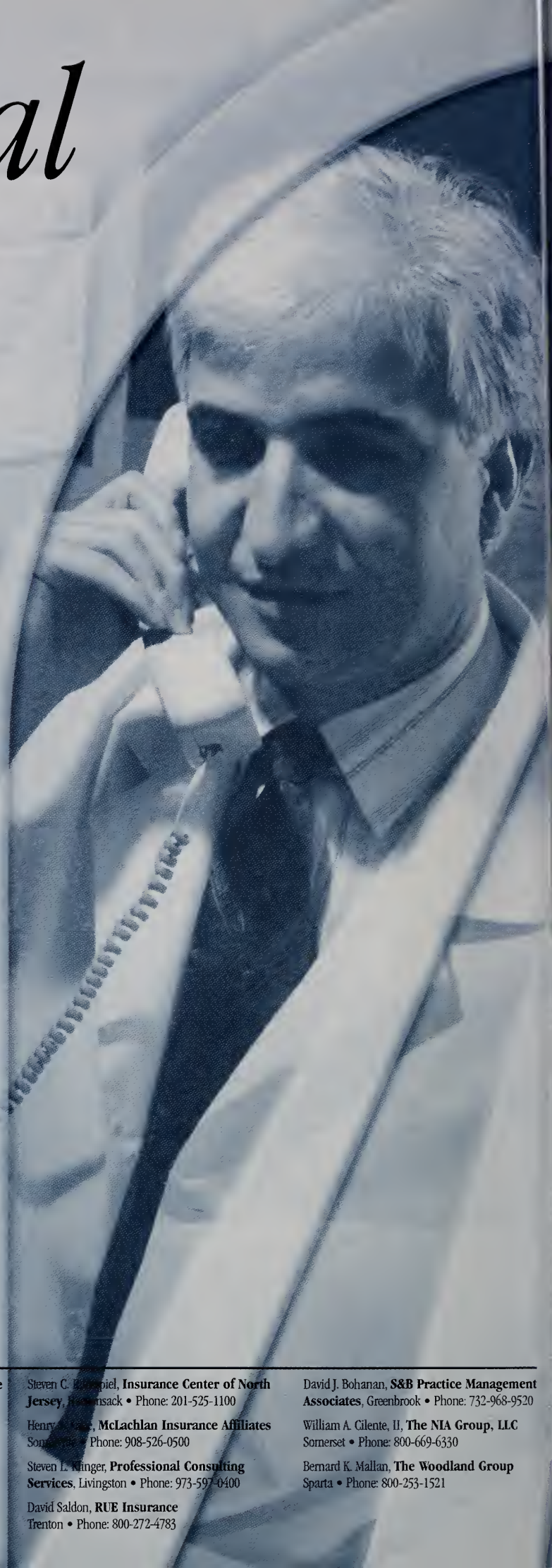
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## ONLINE APPLICATION CHECKLIST

It is important to remember that not all information is created equal. This checklist of questions was created by the US Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Science Panel on Interactive Communication and Health to help judge whether health information offered by an interactive health communication (IHC) application is useful and reliable. Visit the Web site at [www.scipich.org](http://www.scipich.org) for more information.

**Name of Application:**

**URL:**

**Background of**

**Developers/Sponsors**

- Is the identity of the developers and sponsors clearly stated?
- Do the developers have expertise (or use experts) in the content area?
- Is there a mechanism to contact the developers?
- Does the application disclose any potential conflicts of interest or biases of the developers and sponsors?

**Purpose**

- Does the application state its specific purpose?

- Does the application state the intended audience(s) and specific health issue(s) it addresses?
- Do the application's purpose and objectives match the likely needs of its intended users?

**Content**

- Is the original source(s) of the content identified?
- Is the original source(s) of the content likely to be reliable and without bias?
- Is the content sufficiently current to ensure that it is accurate and up-to-date?
- Is the application's method of ensuring the validity of its content reasonable?

**Confidentiality**

- If relevant, does the application specify whether and how users' personal information and anonymity are protected?
- If relevant, does the application specify who has access to information about its users?

**Design**

- Is the application easy to use?
- Are the reading/comprehension level, graphics, audio, and other multimedia features appropriate for the intended user?
- Does it require special and/or high-level technology?

## BOOKMARKS

<http://www.physicianswebsites.com>

The Medical Association of Billers provides billing and coding education and training as well as software. Included on the site are ICD CPT coding education information and software, practice management software, medical and patient accounts receivable systems, physician fees by specialty and ZIP code, as well as links to other health care sites and search engines.

<http://www.ez.md>

eMedius Systems offers .md domain names and medical Web design. Sites already using the .md domain name are available for review, and the site lists frequently asked questions about the use of the .md (e.g., versus .com) domain name, Web site hosting, and e-mail.

<http://www.primemedical.net>

This sites provides links to employment services, e-mail, books, journals, medical supplies, pharmacy sites, health and medical legal issues, patients' rights sites, practice management sites, major medical and health care organizations, major medical references, and general news sites, among others.



**Evaluation Results and Effectiveness**

- Do the developers provide any evaluation results about the effectiveness or impact of the application in the following areas?

If yes, please identify:

- usability of application
- user satisfaction
- changes in user knowledge or attitudes

— changes in health behaviors

— changes in health status (morbidity or mortality)

— changes in costs or use of resources

If evaluation results are available:

- Did the application specify the funding source for the evaluation and potential conflicts of interest of the evaluators?

- Was the evaluation conducted with people similar to the intended target group of the application?

- Did the evaluation compare users with nonusers?

If yes, were evaluation participants randomly assigned to being users or nonusers?

If no, did the evaluation results include a rationale for caution and other possible explanations for the results?

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## E V E N T

## D A T E

## L O C A T I O N

## M a y 2 0 0 0

|                                                                                                      |           |                                                                                                                     |
|------------------------------------------------------------------------------------------------------|-----------|---------------------------------------------------------------------------------------------------------------------|
| <b>American Occupational Health Conference</b>                                                       | May 12-19 | Pennsylvania Convention Center, Philadelphia, (847) 818-1800                                                        |
| <b>HIV 2000: The Battle Continues</b>                                                                | May 13    | UMDNJ, New Brunswick, (732) 235-7430                                                                                |
| <b>2nd International Congress on Heart Disease: New Trends in Research, Diagnosis, and Treatment</b> | May 14-17 | Washington DC, (310) 657-8777                                                                                       |
| <b>Greater New York Physicians Expo</b>                                                              | May 16-17 | Javits Convention Center, New York NY, (212) 216-2000                                                               |
| <b>Digestive Disease Week</b>                                                                        | May 18-24 | Washington DC, (609) 848-1000                                                                                       |
| <b>Current Strategies in the Diagnosis and Treatment of Malignant Gliomas and Meningiomas</b>        | May 20    | Morristown Memorial Hospital, Morristown, (908) 522-2119                                                            |
| <b>12th Annual Pediatric Endocrine Symposium</b>                                                     | May 20-21 | Saint Barnabas Medical Center, Livingston, (673) 322-5777                                                           |
| <b>Evaluation and Management of Syncope</b>                                                          | May 23    | Jersey Shore Medical Center, Neptune, (732) 776-4420<br>Mount Sinai School of Medicine, New York NY, (973) 322-5777 |
| <b>AMNJ Annual Awards Dinner</b>                                                                     | May 24    | Chanticleer, Short Hills, AMNJ, (609) 275-1911                                                                      |

## J u n e 2 0 0 0

|                                                              |          |                                                                |
|--------------------------------------------------------------|----------|----------------------------------------------------------------|
| <b>Age-Related Macular Degeneration Update 2000</b>          | June 2-3 | Sheraton Baltimore North, Towson MD, fax (410) 955-0807        |
| <b>17th Symposium for Computer Applications in Radiology</b> | June 3-6 | Philadelphia Marriott Hotel, (703) 757-0054                    |
| <b>Clinical Spectrum of Esophageal Mobility Disorders</b>    | June 6   | Jersey Shore Medical Center, Neptune, (732) 776-4420           |
| <b>Meningitis</b>                                            | June 7   | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911             |
| <b>Breast Cancer 2000</b>                                    | June 8-9 | Rockefeller Research Laboratories, New York NY, (212) 639-8453 |



# A E N D A

**E V E N T**

**D A T E**

**L O C A T I O N**

**J u n e 2 0 0 0**

|                                                                                           |            |                                                                               |
|-------------------------------------------------------------------------------------------|------------|-------------------------------------------------------------------------------|
| <b>Third International Conference on the Mechanisms and Treatment of Neuropathic Pain</b> | June 8-10  | Renaissance Hotel, Washington DC, (514) 286-0855                              |
| <b>Certified Coding Specialist—Physician-based Exam</b>                                   | June 10    | American Health Information Management Association, (312) 233-1160            |
| <b>AMA Annual Meeting</b>                                                                 | June 11-15 | Chicago Hilton & Towers, (312) 464-5000                                       |
| <b>Rheumatoid Arthritis: A New Look at an Old Disease</b>                                 | June 14    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Nephrology Society Meeting</b>                                                         | June 20    | UMDNJ-Robert Wood Johnson Medical School, New Brunswick, AMNJ, (609) 275-1911 |
| <b>New Anticoagulants—Promises and Problems</b>                                           | June 20    | Jersey Shore Medical Center, Neptune, (432) 776-4420                          |
| <b>Tuberculosis 2000</b>                                                                  | June 20-24 | The Roosevelt Hotel, New York NY, (202) 737-3600                              |
| <b>Chronic Pain Management</b>                                                            | June 21    | St. Mary's Hospital, Passaic, AMNJ, (609) 275-1911                            |
| <b>Nanoscience and Nanotechnology: Shaping Biomedical Research</b>                        | June 25-26 | National Institutes of Health, Bethesda MD, (240) 632-5618                    |

**J u l y 2 0 0 0**

|                                                                                    |                  |                                         |
|------------------------------------------------------------------------------------|------------------|-----------------------------------------|
| <b>Annual Meeting of the American Orthopedic Society for Sports Medicine</b>       | July 2-5         | Washington DC, (847) 292-4900           |
| <b>International Conference on Alzheimer's and Related Disorders</b>               | July 9-14        | Washington DC, (312) 335-8700           |
| <b>13th International Symposium on Treatment of Leukemia, Lymphoma, and Cancer</b> | July 14-18       | New York NY, Imedex USA, (770) 751-7332 |
| <b>Update and Intensive Review in Internal Medicine</b>                            | July 30-August 5 | New York NY, (212) 781-5990             |

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**Current Topics in Health Care** September 13-14 Atlantic City, (800) 940-5860

**American Association of Electrodiagnostic  
Medicine Annual Meeting** September 13-16 Philadelphia Marriott, Philadelphia PA,  
(507) 288-0100

**Certified Coding Specialist—  
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Association, (312) 233-1160

**World Congress of Gynecology and  
Obstetrics** September 17-22 Washington DC, (514) 286-0855

**New Developments in Retinal Disease  
and Vitreous Surgery** September 22 Baltimore MD, (410) 328-5934

**American College of Radiology Annual  
Meeting** September 23-27 New York Hilton & Towers, New York NY,  
(703) 716-7545

**O c t o b e r 2 0 0 0**

**American Society of Human Genetics** October 3-7 Philadelphia PA, (301) 571-1825

**Lymphoma and Myeloma 2000** October 5-7 New York NY, (770) 751-7332

**Contemporary Nuclear Cardiology** October 12-14 Heart House, Bethesda MD, (301) 897-2694

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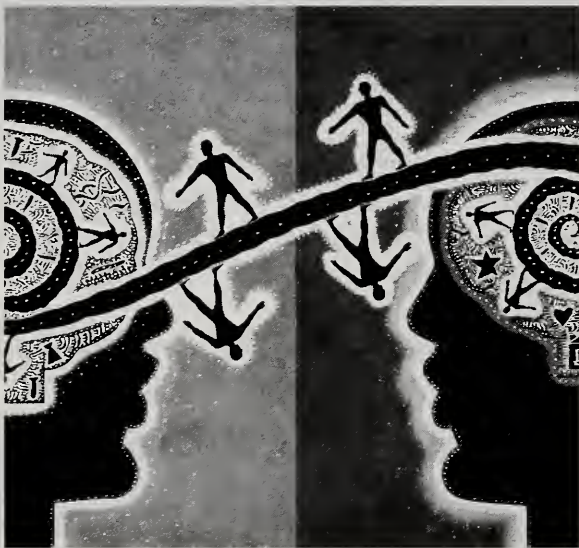


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# REFLECTIONS

## WHY I ENVY ERIN BROCKOVICH

*Peter Blumenthal, MD, MPH*

One recent Sunday I treated myself to the movie "Erin Brockovich." The movie's story line is gripping: A \$38-billion utility company has contaminated the groundwater and adjacent well with hexavalent chromium. As part of an abatement plan, the company has started to buy up surrounding real estate at market value. A price dispute ensues.

Erin Brockovich, newest file clerk at a small law firm, finds medical records of the occupants of the properties mixed in with their real estate files. She is puzzled by the variety and severity of the medical findings. In a moment of distraction, her boss gives her permission to investigate. After a great deal of personal persuasion, Erin convinces 614 parties to join in a class-action suit, alleging that their gamut of medical problems is due to hexavalent chromium-contaminated drinking water. When all is said and done, the plaintiffs collect \$330 million. We are assured that this really happened and amounted to the largest settlement of this kind in US history. The real Erin Brockovich, who made it happen, has earned more than a cameo appearance as a waitress in the film.

Despite the chilling subject, "Erin Brockovich" bubbles right along, carried by a vivacious Julia Roberts in the title role. If she does not keep the viewer engaged, additional interesting characters will: A lawyer who is a pussycat, not a tiger. A biker with a heart. A quiet whistleblower. The movie enjoys competent direction by Steven Soderbergh, a pleasant surprise in the performance of Aaron Eckhart as the loving biker, and an occasional nice shot of the high desert of California. Although the editing is unimaginative, the movie provides a couple of hours of splendid entertainment.

The unlikely heroine has serendipity, the ability to make a fortuitous discovery. She has the drive and determination of David defeating Goliath. She has the communicative skills to draw her clients in. She wins them over with a genuine display of empathy. It's because of these skills that I, the doctor, envy Erin Brockovich.

Earlier this year I had watched another movie, "A Civil Action," with John Travolta in the role of environmental lawyer Jan Schlichtman. This film traces the events in Woburn MA, a town 12 miles outside of Boston where there was a cluster of childhood leukemias (12 cases found versus 5 predicted between 1969 and 1979). The households of Woburn had contaminated drinking water, allegedly from industrial sites.

In Dover Township NJ, a cluster of childhood cancers (90 cases found versus 67 predicted between 1979 and 1995) is being studied. The townspeople think there may be an association with water contamination from a toxic industrial site and its wastewater pipeline. Contaminated wells have since been capped, the aquifer is undergoing cleanup, and the investigation is ongoing.

"Erin Brockovich" and "A Civil Action" remind me of the need to keep my eyes wide open. The stories enforce the need to look beyond the immediate patient, searching for patterns and explanations. We need to see both the forest and the trees. In the movie, as in real life, Erin is unexpectedly rewarded for her troubles. As she fights for her clients, she climbs from beagle to legal eagle, rising from an entry-level clerical job without benefits to a respected force receiving a \$2-million bonus. We should all be as successful in our role as social advocates. ■

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## The governor and the doctors

Governor Whitman signaled the MSNJ House of Delegates on May 5 that her administration will increase physician reimbursement under Medicaid. New Jersey payment rates to physicians have languished unchanged at unreasonably low levels for two decades.

The move is intended to attract physician participation in new programs to fund health care for the working poor, their families, and other currently uninsured populations. New Jersey KidCare now covers 60,000 children, while the nascent FamilyCare program is aimed initially at parents of KidCare enrollees and eventually at 125,000 New Jerseyans.

Further, beginning July 1 the Whitman administration is embarking on a related initiative to enroll 200,000 beneficiaries of state aged, blind, and disabled programs in Medicaid managed care. Performed gradually over seven months, this exercise will increase Medicaid managed care enrollees by about 50%. The target group includes the developmentally disabled.

Initially, Medicaid managed care in New Jersey was intended to make Medicaid beneficiaries as finan-

cially attractive to physicians as privately insured patients. But primary care physicians and numerous specialists—including emergency physicians, radiologists, and anesthesiologists, among others—have grown increasingly bitter about low fee schedules. The

Garden State consistently ranks at the bottom in state surveys of Medicaid payments to physicians.

This year MSNJ lobbyists convened a coalition to press for reasonable pay rates. Irving P. Ratner, MD, now MSNJ's immediate past president, repeatedly tells his colleagues on the governor's health care affordability commission that a reduction in paperwork hassles and an increase in reimbursement are needed to attract physicians to FamilyCare, which, like KidCare, essentially constitutes an extension of Medicaid.

The text of the Governor's remarks to the delegates appears in these pages.

### Status Report on New Jersey HMOs.

During the past six months, leaders of the Medical Society of New

Jersey (MSNJ) have held discussions with representatives of the state's largest HMOs in a continuing effort to reduce the hassle factors and unfairness inherent in HMO conduct toward patients and physicians.

**A** highlight of Physicians Conference 2000 was a Senate Health Committee meeting to take testimony on a bill, S. 1033, to allow independently practicing physicians to negotiate with health plans as a group. Sometimes called "state action" or "joint negotiation" legislation, the bill is strongly supported by MSNJ.

Speaking in favor of the bill were MSNJ president Walter J. Kahn, MD, past president Irving P. Ratner, MD, and Council on Legislation chair Patricia G. Klein, MD. Also speaking in support were: John Sensakovic, MD, Academy of Medicine of New Jersey; Mary Campognolo, MD, New Jersey Academy of Family Physicians; Palma Formica, MD, American Medical Association; and Timothy Clark, New Jersey Dental Association.

Additional supporters included: Sal Pepe, MD, and Mike Gerardi, MD, American College of Emergency Physicians, New Jersey chapter; George Wilson, MD, and Charles Blackinton, MD, New Jersey Psychiatric Association; William Dowling, MD, New Jersey Orthopaedic Society; and William Ryan, MD, office of Congressman Chris Smith.

In the long run, the best way to ensure HMO responsiveness to physician concerns is enactment of legislation allowing independent physicians to negotiate jointly with a large health plan. In the interim,



the discussions with MSNJ test the HMO's interest in becoming physician-friendly and working with physicians to deliver the best care and service to patients. Irving P. Ratner, MD, MSNJ immediate past president, has coordinated the discussions. Participating HMOs are Aetna U.S. Healthcare, Horizon Blue Cross Blue Shield, CIGNA Healthcare, and UnitedHealthcare.

On the basis of discussions to date, MSNJ can report the following to its physician members:

- United has demonstrated the greatest commitment to reducing hassles, partnering with physicians, and improving quality of care.
- Horizon is devoting significant resources to improving an unwieldy administrative infrastructure and is listening to physicians.
- Aetna takes quality of care seriously and is making strides to develop a more responsive information system. However, its heavy-handed attitude toward physicians is entrenched.
- CIGNA so far exhibits no interest in reducing physician hassles or taking physician concerns seriously on the corporate level.

**Smokers Start Young.** Tobacco use prevention faces huge challenges in New Jersey, judging from results of

the state's first youth tobacco survey. Commissioned by the state Department of Health & Senior Services to establish baseline data, the survey showed that about one in five middle school students and two in five high school students use tobacco.

Rates are highest among kids who live with a smoker or whose closest friends smoke. Besides cigarettes, cigars are smoked by about half of the youth smokers. The University of Medicine & Dentistry of New Jersey's School of Public Health conducted the survey.

**Uninsured Patients.** Entrepreneurial-minded physicians in the state will look to the expanded Medicaid managed care programs for opportunities. But, it may be possible to serve the working poor without resorting to government programs.

Two Washington state family physicians, Vern Cherewatenko, MD, and David MacDonald, MD, cut their fees and overhead and opted out of insurance plans in order to focus on uninsured patients. To promote their vision, which they dub SimpleCare, these Evergreen State physicians founded an American Association of Patients and Providers.

An article about caring for the uninsured without trappings is summarized in the *Healthcare Leadership Review*.

**Report Cards Fail.** In another piece, the same review notes diffi-

culties with health plans' report cards on physicians. A review of report cards evaluating a Philadelphia group practice of 19 internists uncovered diverse inaccuracies.

For example, the report cards included results on partial-year enrollees. So a practice was faulted for failing to perform a year's worth of recommended services, such as immunizations, within a fraction of a year for some patients.

In addition, the report cards did not sufficiently capture laboratory data. The practice was faulted for failing to order tests for diabetic patients when in fact the tests were ordered, performed, and reported.

Finally, the study noted that the sample size often was too small to evaluate quality of care validly and reliably.

**Malpractice Is Here.** Physicians' offices are appearing more and more frequently as the site where alleged malpractice occurs. CAN HealthPro, a Chicago-based medical malpractice insurer, found that 45% of a sample of more than 13,000 claims closed between 1994 and 1998 developed in ambulatory care settings. *Medical Liability Monitor* reported the study.

Planning ahead? Physicians Conference 2001 is scheduled for April 20-22.



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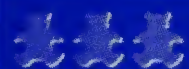
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Cover design by Three Bears.

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## A STRONG VOICE FOR ETHICAL ISSUES

The National Bioethics Advisory Commission (NBAC) was created by executive order of the president of the United States in 1995 to provide advice and recommendations on bioethical issues, especially regarding research on human biology and behavior and the clinical applications of that research. It has been charged further in its charter with identifying "broad overarching principles to govern the ethical conduct of research." The commission does not review or approve individual projects but may cite individual projects as examples or illustrations.

The NBAC has dealt with some of the most challenging issues facing the medical and scientific communities as well as society in general. The news media have covered these issues intermittently but often with extraordinary intensity: human cloning, the genome project, and the use of human subjects in clinical studies. These and other topics are considered by the commission either at the request of the president or on its own initiative.

The commission has 18 members, selected to represent different categories of primary expertise, and is approxi-

mately evenly balanced between scientists and nonscientists. Appointments are made by the president and are for two-year terms, renewable by the president.

Dr. Harold T. Shapiro, president of Princeton University and professor of economics and public affairs, is the chairman of the commission. Although his formal background is not in the sciences, he has been actively involved in medical and scientific affairs for many years and brings a questioning and probing intellect to the commission.

For the interview presented in this issue, *New Jersey Medicine* went to Dr. Shapiro's office in Nassau Hall on the campus of Princeton University. We were impressed with the depth and breadth of his interests and information and with his willingness to answer all questions. He did not hesitate to offer personal opinions on issues that the commission does not have a position on. We found Dr. Shapiro to be an extraordinary resource and a dynamic presence. In dealing with the critical ethical issues that face our profession and the public, he provides a strong and rational voice.

*Paul J. Hirsch, MD; Arthur Krosnick, MD; and Paul W. Armstrong, Esq.*

## NEW JERSEY'S MEDICAL HISTORY

MSNJ, founded in 1766, is the oldest state medical society in the nation. Just as the history of the medical society precedes the founding of the nation, the history of medicine in our state precedes the origins of MSNJ. In fact, New Jersey has a particularly long and varied medical history.

One of the earliest physicians in this area was Dr. Hugh Mercer, who arrived in Philadelphia from Scotland in 1747. He was in his twenties and had graduated from medical school a few years earlier. Dr. Mercer practiced as a physician, fought in the Pennsylvania militia, and later became a close friend and associate of General George Washington. He died a hero in the Revolutionary War while leading his troops. Years after his death, his courage and bravery were sufficiently remembered for Mercer County to be named after him. Interestingly, he was also a direct ancestor of a famous American World War II general—George Patton.

In this issue of *New Jersey Medicine*, Dr. Mercer's life and career are chronicled by Dr. Henry H. Sherk, an orthopaedic surgeon and medical educator who has written many research-based clinical and scientific articles. Dr. Sherk is also an accomplished historian, and has written the comprehensive *Colleagues and Competitors: A Sesquicentennial History of the Camden County Medical Society*.

"Dr. Hugh Mercer: Physician and Soldier" is the first of a series of articles that Dr. Sherk has agreed to write documenting our rich New Jersey medical heritage. Subsequent articles will appear about every other month. The editors are especially proud that Dr. Sherk has chosen to publish his works in our journal.

*Paul J. Hirsch, MD*



## A PROPOSAL TO IMPROVE MSNJ'S RESPONSE TO ISSUES

The annual meeting of the House of Delegates of the Medical Society of New Jersey was held last month. As in the past, there were a great many resolutions submitted by individuals and by county medical societies. Although this process gives voice to many issues, the volume of resolutions and the resulting brief time for evaluation and discussion of them often prevent thorough and careful consideration.

Moreover, the current procedures are out of date in a fast-moving society. Resolutions intended for the House of Delegates may wait for months before the annual meeting and then, if approved, be further delayed by the need to consider and evaluate the best means of implementing the proposals. By that time, our actions may be too late or meaningless.

In this issue, MSNJ Executive Director Vincent A. Maressa has presented a proposal that would allow and encourage submission and consideration of resolutions

throughout the course of the year rather than in the few days of the annual meeting of the House of Delegates.

The process that he proposes would provide continuous access to the Board of Trustees and the membership councils and would further provide the author or authors of a resolution with the advice and support that could enhance the resolution and make it workable. There would be greater access to MSNJ's resources, in a more timely fashion, for all members rather than the delegates only. MSNJ could respond more quickly to membership concerns. The delegates would be provided with more background and information about the most critical issues brought before them and would have more time to deal with those issues.

Mr. Maressa's suggestions deserve careful and thoughtful consideration as a means to enhance the focus and effectiveness of the society as it faces the complex issues that trouble its members and the public.

## A SUCCESSFUL CONFERENCE OF PHYSICIANS

The first annual New Jersey Physicians Conference, held in Atlantic City last month, was an outstanding success!

The annual meeting of the House of Delegates of the Medical Society of New Jersey was only one segment of this extensive and exciting conference.

In a display of unity, more than 33 sponsoring specialty societies and other organizations joined with MSNJ in a combined professional experience that included more than 80 educational sessions and 160 exhibits. At least 1,900 participants attended, including physicians, practice managers, exhibitors, and others.

Particularly impressive was the array of government representatives who attended to address this audience and to meet with those present. Gov. Christine Todd Whitman led the list of prominent New Jersey leaders at the conference. The Speaker of the NJ Assembly, Jack Collins, also spoke at the meeting. The NJ Senate Health Committee, led by chairman Jack Sinagra and minority leader Richard Cody, held a public hearing at the conference, giving many physicians the opportunity to present testimony to the committee. Also testifying before the committee was Mayor Jim McGreevey of Woodbridge.

New Jersey Congressman Bob Franks held a breakfast meeting at the conference, as did state senator Bill Gormley. Congressman Greg Ganske, MD, one of the few physicians in Congress and a cosponsor of the Norwood-Dingle-Ganske legislation before Congress, addressed the closing session of the meeting.

Christine Grant, Commissioner of Health and Senior Services, spoke of her department's efforts and initiatives and patiently answered questions and concerns from a large and appreciative audience.

In short, there was an unprecedented opportunity for physicians to meet with many of the most senior policy makers in our state and to discuss mutual concerns and issues of importance to medical professionals and our patients.

If you attended the conference this year, you are probably already planning to attend again next year. If you missed the conference this year, make certain that you are a part of it next time. Mark the dates: April 20-22, 2001.

*Paul J. Hirsch, MD*

# Physician Profiling: A Better Way

Walter J. Kahn, MD

New Jersey's patients would make better medical decisions if they had Internet access to a doctor's history. So says state Senator Richard J. Codey in April's *New Jersey Medicine* in a discussion of his physician profiling measure, Senate Bill 575.

No argument here. How could any of us oppose having better-informed patients? We can agree with Senator Codey that access to such information as a doctor's education, number of years in practice, office location, office hours, specialty, and other factors would be beneficial.

I do question, though, a critical component of the senator's bill. He thinks patients should know whether a doctor has lost a malpractice case or settled a claim during the past five years. I think that malpractice information, in general, is misleading.

All of us know of situations in which a judgment or settlement appears to have been made because of a poor medical outcome, not because of negligence. What benefit to the patient comes from information about such a case—that a doctor is "iffy" or that a doctor was unlucky once in the legal process? (On the flip side, I suppose Senator Codey could argue that an absence of malpractice actions might mean that a doctor isn't necessarily good—just lucky.)

All of us know doctors who accept high-risk patients and others who conduct high-volume practices. Both know-

ingly increase their exposure to malpractice actions. Does Senator Codey's bill factor in this special information about doctors? No, it does not.

Instead, it focuses on the dollar amount of a judgment or settlement against a doctor, compares it with the experience of other doctors in the same specialty, and then has the amount expressed as average, above average, or below average.

The clear implication here is that the dollar amount is in direct proportion to the doctor's negligence. And if this information is placed on the Internet by the State of New Jersey, what does the patient conclude? That the state thinks that the dollar amount is meaningful, that's what.

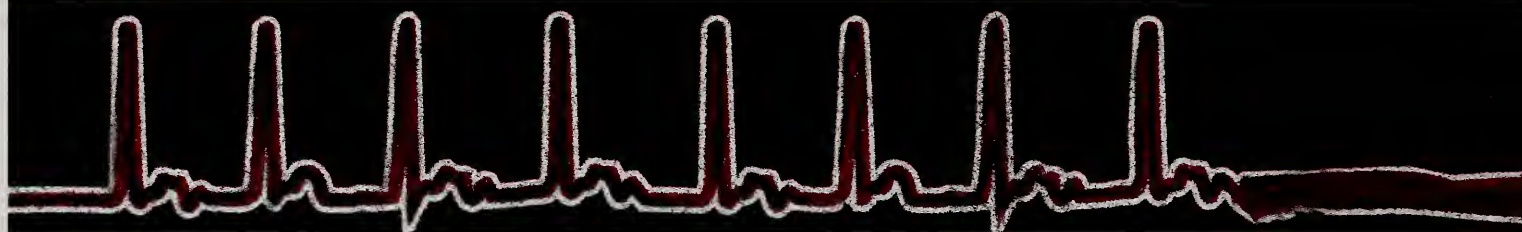
Defense attorneys say that the dollar amount can be more a function of location than case severity. If you're going to be sued in New Jersey, better it should be Burlington County, not Middlesex. Some counties are more conservative than others in the disposition of personal injury cases.

All of which brings me back to my point: as currently written, I think that S-575 propagates the spread of misleading information about doctors.

If the state is going to go to the trouble of publishing an official profile of a doctor, it's our obligation to make the information meaningful—not misleading.



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# Governor's Address to MSNJ House of Delegates

*The following is the speech that Governor Christine Whitman gave at the MSNJ House of Delegates at Physicians Conference 2000 on May 5.*

Good morning. You and I are living through a time of dramatic changes in health care and in our health care system. Each day we read of promising scientific discovery and innovation. We see evidence of this in the topics covered this weekend—the role of genetics, new diagnostic techniques for heart disease, and new therapies for treating illnesses ranging from asthma to vascular disease.

Yet these are also times of uncertainty and frustration. You see the frustration in your offices and in the hospitals. You hear it in the voices of your patients, in discussions with colleagues.

These are indeed difficult times in health care. But difficulties and difficult times are things that show what men and women are. By that measure, you've shown the people of this state that New Jersey's physicians are passionate—and compassionate—advocates for their patients. A good example of this is how you responded to the collapse of the HIP Health Plan of New Jersey and the American Preferred Provider Plan, when more than 200,000 people were left without health insurance coverage. We could have had a health care crisis on our hands, but we didn't. That's because our state's doctors and hospitals made sure that no one who needed care went without. Patient care came first, despite the financial risk involved.

New Jersey's physicians did right by their patients. So it was only right that New Jersey do right by you. Last month, I signed legislation reimbursing physicians and hospitals \$100 million in costs from treating patients of the collapsed health plans. I signed that law because you were there when we needed you.

But our job isn't over. We have to make sure we never ask doctors and hospitals to make that same sacrifice again. We've strengthened our HMO regulations on financial requirements, and I've signed legislation that now requires the licensing of any subcontractors that accept risk. Physicians fight disease. They shouldn't have to fight insurance companies and HMOs. We recognize that slow payment is a big frustration for you, depriving

you and your hospitals of needed income. Here's what we're doing to help. We've enacted prompt-pay laws stating that clean claims must be paid—not in 60 days or 90 days or whenever—but in 30 days for claims filed electronically and 40 days for claims filed on paper. We are actively monitoring these laws because late payment costs everyone—doctors, hospitals, insurers, and consumers.

We are also proposing new rules to make it easier to resolve payment disputes. Often these issues can be resolved quickly, but the trick is knowing whom to call. I've asked the Departments of Banking and Insurance and Health and Senior Services to draft rules requiring that all insurers create a process for resolving payment disputes. In an effort to avoid confusion, that process will be spelled out in contracts with physicians. There will be a toll-free number, as well as an internal and external review. The external review is there as an independent set of ears to resolve disputes. These reviews, by the way, will have strict timelines, so they won't drag on indefinitely. Expect to see these rules proposed for comment in early June.

The proposed regulations, along with our prompt-pay laws, should go a long way toward making sure physicians are paid promptly so you are free to do what you do best—care for your patients.

To help our hospitals, we worked together with the congressional delegation and the Hospital Association so that New Jersey hospitals will receive up to \$465 million in retroactive federal Medicare payments. We've done all this because you are the hands, the heart, and the soul of our health care system. If it isn't working for you, it isn't working for anyone.

New Jersey has earned a reputation for putting the needs of patients first. That was reaffirmed for me last July when the American Medical Association gave me its prestigious Nathan Davis Award, for which I was nominated by the Medical Society of New Jersey. While it's always nice to win awards, this one was especially meaningful to me because it showed the nation what we've been able to do together here in New Jersey. Whether it's our HMO regulations, or patient protections such as the law



that ended same-day mastectomies, or our comprehensive tobacco prevention program, we've done a lot to advance patient rights and protect the doctor-patient relationship.

Our HMO regulations and the Health Care Quality Act are good examples of this. Congress has been unable to agree on a patients' bill of rights for managed care, but New Jersey has a patients' bill of rights that ensures that doctors—not administrators—make medical decisions. Our bill of rights says patients have the right to see specialists, and we've found a way to provide an external review of appeals without rushing into court.

We were one of the first states to hold managed care accountable with annual report cards that allow health care purchasers to see how all the plans perform in important areas, such as preventive care and patient satisfaction.

I'm proud of what we've done, but there are a number of challenges ahead. I said earlier that difficulties are things that show us what we are. One of the biggest difficulties we face is the growing number of people without insurance. New Jersey's charity care reimbursement program is among the most generous in the nation, but it's still a safety net and safety nets don't vaccinate babies or screen for cancer.

This year I am proposing that we take \$100 million from the tobacco settlement to address this problem with an affordable insurance program called FamilyCare. With FamilyCare, we can help 125,000 working New Jerseyans of moderate income obtain the health insurance coverage they need. FamilyCare will reduce the charity care burden. But just as important, it will give adults access to the primary and preventive care they need to stay healthy.

We want our FamilyCare program to do for adults what our KidCare program has done for more than 60,000 children—provide comprehensive insurance. The parents of the children in KidCare will be among the first people we will encourage to sign up.

As we work to provide affordable health care coverage, we also recognize our responsibility to ensure fair reimbursement for medical services. We all know that Medicaid fee-for-service rates paid to physicians have not been adjusted for nearly 20 years. In cooperation with the Medical Society, we've already begun reviewing reimbursement levels, and we'll continue to work on this issue over the next several months.

Insurance is an important way to protect the health of families and children, but here is another way—prevent nicotine addiction.

You all know the statistics. You know that each year, smoking kills more people in this country than AIDS, fires, car accidents, and homicides combined. Unfortunately, young people just aren't getting it. More than 10% of New Jersey middle school students and more than 27% of high school students smoke cigarettes. More than a third of young smokers buy their own cigarettes, despite a century-old law that prohibits the sale of tobacco products to minors.

Our battle to keep kids from tobacco has been made all the more difficult with the recent Supreme Court decision regarding the Food and Drug Administration's power to regulate nicotine. This leaves us with a lot of work to do. We have to change the perception that tobacco use is acceptable. It's starting to happen—more restaurants, offices, and public areas are now smoke-free—but we have to keep reinforcing that message. That's why we are putting \$30 million from this year's settlement toward a comprehensive antitobacco program that features an antitobacco media campaign, school- and youth-based programs, nicotine treatment, and an evaluation component to see if we are spending our money wisely.

These programs will go a long way toward helping change perception, but we have to keep reinforcing the message every chance we get. You have a big role to play here. You are a respected voice. What you say—and what you don't say—has a big impact on your patients, especially young patients.

I began by saying that we are living through a time of tremendous change. Change is scary but it also holds tremendous opportunity.

With our comprehensive tobacco plan, we have the opportunity to reduce the number of children who become addicted to nicotine. Through KidCare and FamilyCare, we have the opportunity to increase the number of people with insurance, thus increasing access to primary and preventive care.

These are also trying times. But how you've responded to the challenges shows New Jerseyans what you are—passionate advocates for your patients. Continue your advocacy, and we'll keep working with you to ensure that New Jersey patients come first and that the doctor-patient relationship remains strong.

I'd like to thank Dr. Irving Ratner for all his hard work as Medical Society President. I also want to congratulate Dr. Walter Kahn, who I am sure will continue the close working relationship the society has with our two commissioners, Chris Grant of the Department Health and Senior Services and Karen Suter of the Department of Banking and Insurance.

Thank you.





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# Harold T. Shapiro, PhD

*President, Princeton University  
Chairman, National Bioethics  
Advisory Commission*

**H**arold T. Shapiro, PhD, is the 18th president of Princeton University and chairman of the National Bioethics Advisory Commission.

Dr. Shapiro received his PhD in economics from Princeton in 1964. He subsequently served on the faculty of the University of Michigan as professor of economics and public affairs and then served as president from 1980 to 1988. He has been president of Princeton University and professor of economics and public affairs since January 1988. He also has had a great deal of contact with issues involving medicine, science, and public policy.

Dr. Shapiro has served as a member of President Bush's Council of Advisors on Science and Technology and chaired the Institute of Medicine's Committee on Employer-Based Health Benefits. While still at Michigan, he served as chairman of the executive board of the University of Michigan Hospitals. He is currently a trustee of the University of Pennsylvania Medical Center, chairman of the Alfred P. Sloan Foundation, and a member of the Institute of Medicine.

But it is as chairman of the National Bioethics Advisory Commission, a position to which he was appointed by President Clinton in 1996, that Dr. Shapiro has had perhaps his





greatest impact on medically related issues.

*New Jersey Medicine* (represented by Editors Arthur Krosnick, MD, Paul Armstrong, Esq., and Paul Hirsch, MD) interviewed President Shapiro in his office in historic Nassau Hall on the Princeton University campus. (See the related editorial in this issue.)

**NJM:** Dr. Shapiro, you were appointed as the first chairman of the President's Commission on Bioethics by President Clinton in 1996. What are the issues that you have dealt with since then?

**President Shapiro:** The agenda-setting of the Bioethics Commission comes from two sources: requests from the president and issues that are generated by the 18-member commission itself.

The president has made three requests. One had to do with the issues surrounding cloning of human beings, occasioned by the birth of Dolly [the cloned sheep]. The president asked for advice on the development of public policy with respect to the cloning of human beings.

Another request from the president related to the derivation and use of embryonic stem cells in research and recommendations for public policy with respect to federal funding.

The third issue was cross-species genetic engineering. Around the time that the embryonic stem cell

issue broke, someone claimed to have used a cow oocyte and a nuclear transfer from a human being to generate embryonic stem cells that the researcher felt "looked" human. There has been no verification of that and no replication.

Although the president's requests take precedence, the commission has also generated its own agenda. One issue was the use of people with mental disorders as human subjects in medical experiments. Another, for which a report has been issued, relates to the use of tissue in tissue banks.

We are currently working on a report that deals with international research and will consider the ethics that apply when US researchers or dollars go abroad for medical experiments. Our concern is whether to uniformly apply our own ethics or to make allowances for other cultural approaches.

We are also reviewing the overall structure of human-subject protection and how we can improve it.

**NJM:** What do you expect will be the mission of the commission in the future?

IT IS STILL AN OPEN  
QUESTION AS TO WHETHER  
WE WERE REALLY  
READY FOR [GENE  
THERAPY] TRIALS.

**President Shapiro:** There have been several bioethics commissions in the past and all have been short-lived. We are now serving the longest of any. If our commission does continue, we will carry on our agenda of addressing issues of ethical concern that arise from progress on the biomedical frontier. These issues will relate to the use of human subjects and such other areas as genetically modified crops. Farmers have been genetically modifying crops through selective breeding for centuries—even millennia. Modern techniques that allow major change or use cross-species modification, however, may upset the ecosystem in unexpected ways. That is a new development about which public policy must take a stance.

Gene therapy is an area in which there have already been many clinical trials, but it is still an open question as to whether we were really ready for those trials. The vector that is used to deliver the materials to the appropriate sites is critically dependent on the immune system. Different animals have different immune systems. It is hard to know when enough animal experiments have been done because of the great sensitivity of the delivery mechanism to the immune systems. The role of the commission is to help guide public policy in these areas.

**NJM:** What have you learned about the way basic biological and

pharmacological research is conducted in this country?

**President Shapiro:** I have a fair degree of confidence in research that is sponsored or carried on directly by pharmaceutical companies and therefore falls under the supervision of the Food and Drug Administration (FDA). I have less confidence in research that is not covered by a multiple project assurance agreement that an academic health center might have with the federal government or does not fall under the FDA's aegis. There would be no regulations that apply. We know more in this country about how many animals are used in research projects than about how many humans are used.

Some human subjects in this country do not have the benefit of the two pillars of our human protection, which are independent review and informed consent. Informed consent is an obvious requirement, because we should not touch people without their consent. Independent review is necessary, because we should not use something as valuable as a human subject unless there is an important scientific or clinical result anticipated or hoped for and the investigator is competent to carry it out.

**NJM:** What can be done to help prevent some of the difficulties that have occurred?

**President Shapiro:** Whenever an investigator is less than fully compe-

I HAVE A FAIR DEGREE OF  
CONFIDENCE IN RESEARCH  
THAT IS SPONSORED OR  
CARRIED ON DIRECTLY BY  
PHARMACEUTICAL  
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tent, we should not use human subjects. Some investigations involve such a low level of risk and such a low level of discomfort that you would not want to create a complicated process to allow that research to go on. An example might be a project that involves taking blood pressure once a month. But if there are genuine risks, the competence of the investigator is critical. If you do not have that, you are exposing people to risks inappropriately.

I am told that there are cases in which a physician in practice is asked to test a product. I have concerns about that. The design may be wonderful, and the test product tried might be entirely desirable. But if the last link in the chain is an investigator who is not clear about the possible actions or side effects of the drug, it is very worrisome.

**NJM:** How should the competence of the investigator be measured, monitored, and ensured?

**President Shapiro:** Those are three different things. "Measured" is principal and is the easiest question. My view is that part of a proposal should delineate the characteristics of the investigator—for example, board certified plus other specified credentials.

"Monitored" is a much harder question. That is where our entire system lacks accountability. Even when we look carefully at informed consent and independent review, we do not have procedures to ascertain and ensure that everyone follows the research protocol as designed and as approved, and we do not necessarily know about adverse effects. We do very little monitoring. It is mostly self-reporting. We need a system of auditing to ensure that the process works as intended. It would not be necessary to audit every case or every study. Random audits would help people remember what their responsibilities are.

**NJM:** Dr. Shapiro, what do you think about the usefulness of clinical research, when much of it is done primarily on adult males? Few females or children are included in most studies.

**President Shapiro:** It is important to select human subjects fairly. We ought not select research subjects from one human population and give the benefits to another popula-



tion. We ought not put the burden of being a human subject on men and give the benefits to women. At the same time, we want to make sure that the research that is being done can be of equivalent benefit to men, women, and children. We must compose our samples to justly distribute the burden of being a subject and also justly distribute the benefits. Recent efforts to try to distribute the burden of being a subject and to design the experiment so that the benefits flow to all groups to the extent possible are quite important. I favor this development of inclusion.

**NJM:** What role do you think the FDA or institutional review boards (IRBs) should play in terms of providing inclusiveness?

**President Shapiro:** I think IRBs should insist on inclusiveness unless there are persuasive reasons not to. For example, if a disease affects only children, it would be silly to include adults. Nevertheless, the goal should be inclusiveness in all relevant studies. It is an important obligation and IRBs should insist on it.

**NJM:** In the past, most IRBs were university or hospital IRBs. They were unable to handle the volume, so that central IRBs, which are for-profit organizations, were formed. Do you see any problem with this?

**President Shapiro:** The problem is not whether IRBs are for-profit or not-for-profit organizations. Nevertheless, they have two prob-

lems. One is that most IRBs are not sufficiently supported, and they are not able to put enough time into the review. Many IRBs are overworked.

More important than that—and I'm now speaking for myself—I believe that IRBs should be audited so that they will be publicly accountable for what they do. The results of these audits ought to be made public. Then we would not have to worry whether an IRB is a for-profit organization or not. The key issue is public accountability whenever you are using human subjects.

The audit of the IRBs would need to be at the federal or the state level. Perhaps the FDA could be given this responsibility. The Veterans Administration is going to institute a process to accredit IRBs rather than use an audit system. IRBs will be examined over time in much the same way that hospitals are accredited. I have less faith in the accrediting mechanism, having watched it in operation at hospitals and universities. I think that an audit is better, but there is room for discussion.

WE KNOW MORE IN THIS  
COUNTRY ABOUT HOW  
MANY ANIMALS ARE USED  
IN RESEARCH PROJECTS  
THAN ABOUT HOW MANY  
HUMANS ARE USED.

**NJM:** Patients are troubled by the high cost of medications. Of course, it costs the pharmaceutical companies hundreds of millions of dollars to do research. But our patients serve as subjects in clinical trials and make it possible to test these products. Yet when the studies are done and the medications are available, many patients cannot afford them. Is there a bioethical issue here?

**President Shapiro:** No one compels patients to volunteer for participation in these experiments. It is a voluntary decision, and I do not believe that they have greater moral status than anyone else when it comes to delivery of the product.

The issue of whether drug prices are too high is very complex. If prices were lower, there might not be the same level of innovation and new drug creation that there is now.

Drugs are cheaper elsewhere. But most of the innovation takes place here, in the United States. Other people are, in a sense, free riders. European drugmakers often will not consider developing a new drug unless they believe that they can sell it in the US market, because they can never obtain an adequate return by selling it in the European or Canadian markets. Therefore we are shouldering a greater burden in this country. Perhaps we should; we are the richest nation. It is an issue that I have not yet resolved in my own mind.

**NJM:** A few years ago, Professor James Watson, in a lecture at Princeton, discussed the ethics of the genome project. He was most concerned about who was going to control the data that came out of the project. Would you comment on that?

**President Shapiro:** As you know, the genome project as we understand it involves the sequencing of human DNA of a "composite person." We hope that we can then take a sample from you or me or anyone else and compare it with that and learn something. We know that most of our DNA is the same. The privacy and the confidentiality issues arise once this is done. Access to this data is a serious concern but part of it is self-inflicted. We have social institutions in our country that allow a certain amount of mischief.

Consider, for example, health insurance. It would be a problem if your health insurer were to learn that you had genes that made you more susceptible to some disease. But if we had a community-based rating for health insurance in this country, if everyone paid the same and we took care of people as needed, the information about an individual's genes would be of no interest to the insurers. So the potential harm—that someone will find out about your genes and not give you access to health insurance—is entirely self-inflicted. We could have a different set of social institutions.

**I BELIEVE IN THE AUDIT  
OF IRBs, SO THAT THEY  
WILL BE PUBLICLY  
ACCOUNTABLE FOR WHAT  
THEY DO.**

There are also other issues, including possible employment discrimination. President Clinton has spoken about this. Employment discrimination based on these criteria is now illegal in the federal government.

Remember that genes aren't everything. The genes only indicate very complex probabilities. Most human characteristics derive from the interaction of many factors that we do not fully understand. When we get away from a knee-jerk reaction to genetic determinism—that it is "all in the genes"—we will recognize that this data is not so sensitive as people fear. Even so, we ought to take whatever precautions we can.

It is going to be difficult to maintain privacy. If people can break into the Pentagon computers, they will be able to break into a hospital data bank. In the end, however, I don't think that it will be a big problem if we can make the appropriate changes in our social institutions.

**NJM:** People may expect too much of the genome project. Professor Watson, in his talk, said

that when we finish with the genome project, we would be able to cure diabetes. Others involved with the project have expressed doubt and indicated that it will not be that easy—it will require a lot more work.

**President Shapiro:** I am not a physician or a biologist, but my view is that the genome project, that is, the sequencing of DNA is going to provide the foundation of a very tall building, which will remain to be built. It will be very difficult and take a long time to go from the information that is encoded in the DNA to phenotypical results—for example, the result of what it is that causes diabetes.

Some diseases may be helped quickly, but I think that will be the exception. For the most part, it will probably take generations to figure out how these complex interactions work to produce a phenotypical result in a particular individual.

**NJM:** After the cloning of the sheep Dolly, you, as chairman of the President's Commission, were asked to produce a report on cloning within 90 days. How did you go about this?

**President Shapiro:** The 90 days were really 60 days, because of the time that it would take to get the report produced and to comply with various regulations. It was the great generosity of my colleagues here on the campus and the trustees of the university that allowed me to devote quite so much time to it.



The day I got the letter, I called a meeting in Washington with a few members of the National Bioethics Advisory Committee. We met that evening and discussed what we would have to know to report to the president. We considered who could provide that information. For example, I had to be sure that every member of the commission understood the science. There are others like me on the commission who do not know a lot about developmental biology or embryology. We identified a group that could give us seminars on the science.

Then we considered who could think carefully or had thought already about the ethical issues. One group was religious thinkers. Many of the issues that are considered by religious thinkers are quite different from what we were considering. But they had developed intellectual resources to think through such problems. The testimony of the major religious faiths was intriguing, even though they disagreed widely.

There have been some philosophers and scientists who have been thinking about cloning since the 1960s. Even then, some had begun to think about cloning as a way to improve the human gene pool. Cloning was an enormous controversy in the late 1960s and early 1970s, and then it disappeared because people thought it would

never happen. But there were people around who had really thought about this issue.

We invited many people to talk to us. And they came from all across the country and from Canada and the UK. They came because there was a lot of commotion about this and a lot of emotion. We had a very intensive few weeks in which we heard testimony during the day and wrote at night. E-mail proved to be a lifesaver because we could exchange ideas and draft proposals very quickly.

We reached the most important insight very quickly: that whatever one might think about the ethical issues involved, this was not a safe procedure for human beings at this time. It was therefore inappropriate, both professionally and ethically, to expose human beings to anything like this at the moment. We knew within days that this was not something that people should proceed with now, even if we could not settle all of the ultimate issues.

We also had to distinguish this kind of cloning from cloning cells, which is at the base of much of

modern biology. Some legislation that was introduced in various states and in Congress in the days following the news of Dolly would have virtually required that we stop modern biology.

My favorite moment in all the public hearings occurred when a representative of the National Conference of Catholic Bishops testified, followed immediately by an Orthodox Jewish rabbi. They both started with a quotation from the Bible, which is perhaps not surprising. But it is a big Bible, and they each selected the exact same verse. However, they reached completely opposite conclusions. We knew then that our job was to tell the country that there are different moral perspectives on these issues. We must understand and respect each other before we are able to reach a decision.

**NJM:** What is the role of the commission in translating findings into public policy initiatives?

**President Shapiro:** The impact of our studies occurs primarily at the state level, because of our constitutional setup. Regulation of medical practice is a state function.

A very good example before us now is assistive reproductive technology. Every few years or even months there are new techniques. This area has developed without public oversight, because the federal government eschewed any interest in

THE KEY ISSUE IS PUBLIC  
ACCOUNTABILITY  
WHenever YOU ARE  
USING HUMAN SUBJECTS.

this. We hardly know what is going on. We do not know how many human subjects are being used, we do not know the distinction between clinical practice and research in this area, and we do not know the difference between innovative therapy and generally accepted therapy. There are virtually no animal studies done and yet we are carrying out these procedures on tens of thousands of American women.

This is undoubtedly a state issue, but it is an extremely interesting constitutional issue. That is: are we entitled to write regulations in an area dealing with human reproduction? The Supreme Court has put a "privacy fence" around the standard techniques that are known. The question is, what would we advise the Court and the states? I would very much like to have the commission take a look at this area.

**NJM:** Do you think that insurers should provide for infertility treatment?

**President Shapiro:** I have my own view on that. Procedures in which efficacy and safety have been demonstrated should be treated in a parallel way to other gynecological and obstetrical procedures. Those who cannot have children in the traditional way have the same desire to have children, and there is no reason that we should not help them. But it must be demonstrated that the clinical procedures are appropriate and successful. We do not know very

## [CLONING IS] NOT A SAFE PROCEDURE FOR HUMAN BEINGS AT THIS TIME.

much about success rates, which are usually not reported.

We must share information with the public, so couples can make sensible decisions. People who want to use these procedures should be able to make informed decisions. I have interviewed a large number of people who have gone through these procedures. Many are extremely happy that they have done so. But it is a totally different personal experience from having children in the traditional way. There are third and fourth and fifth parties involved. It is very structured and mechanical. It is quite different from the way a family would traditionally have a child, and it alters traditional definitions of family. I worry about those people.

**NJM:** In response to the Institute of Medicine report regarding medical errors, there have been "do ask, do tell" proposals regarding reporting of individual physician's malpractice experience. Do you think that this will be meaningful or helpful information for the public?

**President Shapiro:** This is also a complex issue. We know, for exam-

ple, that death rates and survival rates from cardiac bypass surgery differ depending on the nature of patients that a surgeon cares for. No single number can effectively summarize this. But one must have faith that information properly presented will have its impact over time, even though occasionally it might be misused or even abused.

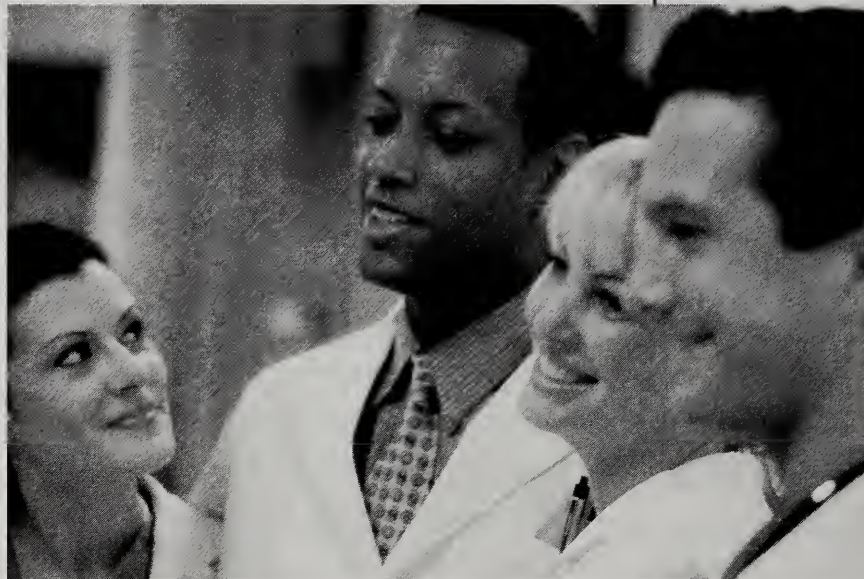
**NJM:** Medical school graduates have historically recited the Hippocratic oath. What role do you think that oath has in the new millennium?

**President Shapiro:** The important parts of that oath are as relevant as ever. It is a good place to start. But a lot has changed. It is highly useful for medical students to make a commitment to the Hippocratic oath or to something similar. But students should also recognize that there are additional ethical requirements that are not always covered by this oath.

They will discover when they are residents that there are ethical issues that come up every single day. Training in medical ethics in the medical school curriculum is not always taken seriously, either by the faculty or by the students. It is not likely to be taken seriously until it is included in the various national exams. Those who teach medical ethics have a very hard time keeping the attention of the students. But things are changing in the right direction.



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# INVESTING TOBACCO SETTLEMENT MONIES WITH CARE

*Assembly Speaker Jack Collins*

One of the most important health care decisions now facing the New Jersey Legislature is how the state should spend the \$7.4 billion it is to receive from the recent settlement of the historic 46-state lawsuit against the tobacco industry.

Different states have chosen to spend these settlement funds in a variety of ways, and there is no shortage of proposals for how New Jersey should spend our portion of this revenue windfall. Many of the ideas have merit, and not all of these proposals are directly related to health issues.

Like many other legislators, I support the concept of using a large portion of the tobacco settlement funds to pay for essential health care programs and services. In her recent

budget address, Governor Whitman proposed using \$200 million per year from the tobacco settlement funds to support a variety of health care initiatives.

The governor has recommended that \$15.1 million of the tobacco settlement, along with federal matching funds, be used for supplemental charity care to provide more hospitals with some reimbursement for the medical services they provide to New Jersey residents without medical insurance. Without question, this is one of the most important health care issues facing the state of New Jersey.

Hospitals would be eligible to receive money from the Supplemental Charity Care Fund if they provide charity care in excess of 1% of their annual revenues. These funds would be made available in

addition to the \$523 million in state and federal charity care funds already included in the governor's proposed fiscal year 2001 budget.

It is also important for the state to look at new initiatives to help ease the charity care burden placed on New Jersey hospitals. In January, Governor Whitman recommended spending \$100 million of the tobacco settlement to create the New Jersey FamilyCare program, which would help about 125,000 low-income residents obtain health insurance.

The FamilyCare program will be modeled after New Jersey's KidCare program, which has already provided health insurance coverage for 55,000 children of low-income families throughout the state. By helping low-income residents obtain health insurance coverage, we



can reduce the cost of charity care and ease some of the financial burdens it places on New Jersey's hospitals.

I do have a growing concern about the financial stability of New Jersey's hospitals—a concern that was only heightened when I recently read that two out of every three hospitals in the state are losing money. According to this report, the hospital industry posted a combined loss of \$160 million last year.

Reversing this trend will require hospital executives, medical professionals, managed care companies, and state government to more closely examine the factors which are causing the negative margins at many hospitals—including the burden of charity care.

Aside from providing much-needed support for our hospitals, there are several other issues that the tobacco settlement money can be used to address.

The governor has proposed spending \$10 million of the settlement funds for cancer research and treatment programs, and I applaud

this effort to ensure that every one of our residents fighting cancer can receive the best care possible right here in New Jersey.

She has also proposed spending \$30 million on a comprehensive tobacco control program aimed at preventing young people from using tobacco products, which I also believe is an appropriate use for some of the funds. But, as I have said, not all of the programs for which tobacco settlement dollars are earmarked need to be directly related to health care issues.

I have proposed, and the administration has agreed, that we annually use \$100 million of the tobacco settlement monies as part of a financial plan for building new schools to replace the outdated educational facilities that now exist in many districts.

The school construction proposal now being considered in the legislature is vital to New Jersey's future educational needs. For many years, we provided funding for medical treatment and health care services to residents who suffered from a variety of smoking-related illnesses. Some

would argue that the monies used to fund those programs over the years could have been used to build schools or perhaps provide additional financial support for other essential state services.

In my opinion, we have a unique opportunity to use some of the tobacco settlement money to improve and enhance the learning environment in school districts throughout New Jersey. Improving the quality of education in our school districts will improve our ability to better educate our young people about the dangers of smoking.

We in the assembly are committed to working with the Whitman administration and our colleagues in the senate to ensure New Jersey's portion of the tobacco settlement is invested wisely and prudently to benefit all citizens.

At the same time, we pledge to continue working toward helping New Jersey hospitals get back on sound financial ground.

*Jack Collins represents Legislative District 3, which includes all of Salem County and parts of Cumberland and Gloucester Counties.*

# Suggestions for the House of Delegates

Vincent A. Maressa

Since we have recently completed a session of the House of Delegates with an innovative Physicians Conference 2000, I thought it might be timely to reflect on the society's annual meeting.

## MSNJ Functions Year Round

MSNJ is headquartered in Lawrenceville and has a full-time professionally competent staff who, along with the Board of Trustees and various councils and committees, advances and advocates the interests of physicians in New Jersey. The Board meets monthly and its meetings are open to all members and representatives of county societies as well as specialty societies. The councils and committees meet on a quarterly schedule, and their meetings are open to all members as well as representatives from county and specialty societies. To place an item on the agenda of any of these organizations, a physician need only initiate a written request. Any issue presented is given careful review. The staff provides legal and technical research, and the physicians serving on the councils and committees have an acquired expertise in the topic under review. The result is a well-reasoned and deliberate conclusion.

## The Resolution Process in the House of Delegates

The current process in the House of Delegates, in contrast, is neither deliberate nor reasoned. Proponents of resolutions are not obliged to authenticate the statements they make, nor are they required to appreciate the nature or consequences of the actions they

propose. While it is true that the reference committee process and debate in the House does tend to depress some volatility, it is also true that decisions are made predominantly on the basis of emotion rather than analysis and logic. Whether you are making a business decision or a medical decision, you are far better served by the application of analysis and logic than you are by emotion. The current process has been used with little variation for more than 200 years, but the socioeconomic, political, and practice environment has changed dramatically in that time. We must consider a new system as we move into the world of e-commerce.

## A Proposal to Consider

Here is what I would do if designing something for the current environment:

- The Board of Trustees would present one or more topics for the House to act on. Their reports are voted up or down but cannot be amended.
- Each county society and each credentialed specialty society can present one issue for consideration. It can be voted up or down but cannot be amended.
- Since the society does function throughout the year, individuals would be encouraged to present their thoughts to the Board of Trustees or a standing council or committee at any time rather than by resolution at the annual meeting. Consequently, a prompt and efficient solution would be available to them on a regular basis and they would not need to wait for the annual meeting.

The above proposal is designed to bring a discipline and selectivity to issues presented at the annual meeting. Individual members are better served because their issues are addressed by a council or committee of their peers on a timely basis. County and specialty societies gain stature because resolutions are funneled through them; if they think they have more than one really worthwhile idea in a given year, they can test their persuasion skills by prevailing on another county that has not presented an issue to do so on their behalf. In this way, there would be more care and concern at the annual meeting and an increased appreciation of the consequences of a proposed action, while individual delegates and members would have a year-round method of addressing their individual concerns on a timely basis. Even this process would permit more than 30 items to be considered, but there would be an establishment of priorities by this limitation. It really is not restrictive when you consider that the average corporate shareholders' annual meeting contains only three to six items for consideration.

I do hope you will reflect on these thoughts with the perspective that I am trying to urge positive change. You all work too hard and give too much to continue with the system we now have, which actually works as a deterrent to focusing on important issues. Please address your comments and criticism to *New Jersey Medicine*, so I do not take them personally.

Vincent A. Maressa is executive director and general counsel, Medical Society of New Jersey, Lawrenceville.



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# Radiation Risks of High-Dose Fluoroscopy

RADIATION-INDUCED SKIN INJURY IS AN UNDERDIAGNOSED, SIGNIFICANT COMPLICATION FOR PATIENTS UNDERGOING FLUOROSCOPY-GUIDED INTERVENTIONAL PROCEDURES. WITH PROPER EQUIPMENT, FLUOROSCOPIC TECHNIQUE, AND PHYSICIAN EDUCATION, PATIENT RADIATION EXPOSURE CAN BE DECREASED BY 75% OR MORE AND SKIN INJURIES CAN BE MINIMIZED.

*Julie K. Timins, MD, FACR and Jill A. Lipoti, PhD*

Many innovative interventional medical procedures requiring fluoroscopic guidance have been developed in recent years. Examples include cardiac catheterization with radio-frequency catheter ablation for cardiac arrhythmias, embolization procedures for treatment of arteriovenous malformations and tumors, and TIPS (transjugular intrahepatic portosystemic shunt) for treatment of portal hypertension. These procedures are lengthy and complex, with long fluoroscopic-exposure times, and can result in significant radiation exposure to the patient.<sup>1</sup>

The Food and Drug Administration (FDA) has issued recommendations to quantify and limit patient radiation exposure. These guidelines include establishing standard procedures and protocols for interventional studies, measuring radiation exposure rates for fluoroscopy equipment, and developing tech-

niques to minimize radiation dose.<sup>2,3</sup> It is also recommended that information be recorded in the patient's permanent medical record to enable estimation of the absorbed dose to the skin for any procedure with the potential to induce skin damage.<sup>4</sup>

## Radiation Injuries

The organ system most frequently injured is the skin. Dermatological effects of radiation exposure are dose related and include, in order of increasing severity: erythema, hair loss, dry and moist desquamation, and chronic skin ulceration requiring excision and skin grafting (see Table 1). Patients at greatest risk are those who undergo repeated procedures or whose interventional procedures are unsuccessful and take more fluoroscopy time. Time to the appearance of radiation-induced skin injury depends on dose, ranging from hours for transient erythema, to four weeks for desquamation, to 10 weeks to more than one

year for dermal necrosis. The skin closest to the X-ray source receives the highest radiation dose. For cardiac catheterization procedures, this is the skin of the central midback (see Figure 1). Because of the time delay in the occurrence of most skin injuries and the less obvious location on the midback, most injuries go unnoticed and unreported. In one study, 22% of patients undergoing radio-frequency catheter ablation received a radiation exposure of more than 2 sievert (Sv) and were therefore at risk for significant skin injury.<sup>5</sup> (1 Sv is equal to 100 rems, and 1 gray is equal to 100 rads. For X rays, 1 Sv is the equivalent of 1 gray.)

Patients receiving very high levels of radiation exposure from interventional procedures have roughly a 5% increased risk of developing skin cancer. However, of greater concern are life-threatening malignancies. Catheter ablations result in a low but statistically significant increased risk





A.



B.

*Figure 1. Skin Ulceration Following Cardiac Catheterization and Angioplasties. This male in his sixties was seen 18 months after three fluoroscopy-guided procedures: cardiac catheterization followed immediately by unsuccessful coronary artery angioplasty and repeat angioplasty the following day. Total fluoroscopy time was approximately five hours and calculated dose was more than 3,000 rads (30 Gy). (Courtesy of Fred A. Mettler, Jr, MD.)*

of fatal malignancy, estimated at 0.2% higher than the unexposed population, based on a mean radiation dose of between 0.017 to 0.025 Sv per patient.<sup>5</sup> These malignancies include breast, lung, and stomach cancers and leukemia. This risk must be balanced against the life-threatening conditions necessitating the procedure.

#### Factors Influencing Radiation Dose

Reported radiation exposure for a given type of procedure varies markedly, depending on the medical institution, the fluoroscopic equipment, the proficiency of the interventional physician, and the age, size, and sex of the patient.<sup>6</sup> By far

the most important factor is the physician performing the study. More experienced, radiation-conscious physicians use less fluoroscopy time and complete

procedures faster. Mean fluoroscopy times vary among physicians and medical institutions by as much as sixfold.

**PATIENTS AT GREATEST RISK ARE THOSE WHO UNDERGO REPEATED PROCEDURES OR WHOSE INTERVENTIONAL PROCEDURES ARE UNSUCCESSFUL AND TAKE MORE FLUOROSCOPY TIME.**

#### Solutions

There are many ways to reduce radiation exposure during interventional procedures.

**Physician Education.** Most important is physician education and training in radiation safety and techniques to reduce radiation exposure. The concept of keeping radiation dose as low as reasonably achievable (ALARA) should be stressed.



**Patient Monitoring.** Periodic patient follow-up for evaluation of late dermatologic injuries is a powerful learning tool and provides for timely treatment. Cumulative radiation exposure of all interventional patients should be tracked and data reviewed periodically by the institutional radiation safety committee. This raises awareness and identifies problems in need of remediation.

**Fluoroscopic Technique.** Fluoroscopy output can be pulsed instead of continuous, resulting in one half to one quarter the radiation dose of continuous exposure systems.<sup>7</sup> Low dose settings should be used whenever possible. The operator should optimize fluoroscopic controls, including increasing the peak kilovoltage (kVp), decreasing the milliamperes-seconds, and controlling television-monitor brightness settings related to kVp exposure.<sup>8</sup> There should be careful collimation

## MEAN FLUOROSCOPY TIMES VARY AMONG PHYSICIANS AND MEDICAL INSTITUTIONS BY AS MUCH AS SIXFOLD.

of the X-ray beam, rotation of the tube position when feasible, limited use of magnification, and minimization of the distance between the patient and the image intensifier. Tube rotation and alteration of the viewing angle will change the body surface receiving maximal radiation exposure, decreasing the risk of excessive skin radiation.<sup>9</sup>

**New Technology.** Digital enhancing technology offsets image degradation caused by decreased radiation output and provides additional benefits, such as freezing the last fluoro-

scopic frame on the television monitor screen. Further dose reduction is achieved with digital acquisition and archiving instead of cine film recording. The recent development of directly monitoring patient exposure greatly assists the interventional staff.

**Quality Control.** A continuing quality improvement program should be implemented, including regular equipment maintenance and inspection. Protocols for procedures should be reviewed and updated periodically. Physician, staff, and patient radiation exposure logs help pinpoint problems. Quarterly fluoroscopic exposure analysis by the radiation safety officer or radiation safety committee is recommended.

## Regulatory Initiatives

The FDA has presented proposed amendments to fluoroscopic equipment standards at meetings of its advisory committee, the Technical Electronic Radiation Safety Standards Committee. New equipment would be required to provide a real-time display of exposure rates and cumulative patient exposure during the procedure and to be able to display the last fluoroscopic image. Regulatory changes would also affect X-ray beam quality, X-ray field limitation, and maximum exposure rates. User manuals would be required to provide additional information to better describe optimal fluoroscopic modes of operation. The New Jersey Commission on Radiation Protection is awaiting the publication of the FDA's pro-

| Effect                   | Single-Dose<br>Threshold (Gy) | Onset    | Peak  |
|--------------------------|-------------------------------|----------|-------|
| Temporary epilation      | 3                             | ~3 wk    |       |
| Permanent epilation      | 7                             | ~3 wk    |       |
| Early transient erythema | 2                             | hours    | ~24 h |
| Main erythema            | 6                             | ~10 d    | ~2 wk |
| Dry desquamation         | 10                            | ~4 wk    | ~5 wk |
| Moist desquamation       | 15                            | ~4 wk    | ~5 wk |
| Late erythema            | 15                            | ~6-10 wk |       |
| Secondary ulceration     | 20                            | >6 wk    |       |
| Dermal necrosis          | 18                            | >10 wk   |       |
| Dermal atrophy           | 11                            | >14 wk   |       |
| Telangiectasia           | 12                            | >52 wk   |       |
| Invasive fibrosis        | 10                            |          |       |

Adapted from Wagner et al. *Journal of Vascular and Interventional Radiology*, 5:71-84, 1994. Used with permission.

Table 1. Skin Effects After Single-Fraction Irradiation.



posed regulatory changes, anticipated later this year, before revising state regulations.

Mandatory education on radiation safety and the appropriate use of fluoroscopy has been suggested, although no federal regulations exist. Physician education and credentialing requirements fall under the auspices of state licensing boards, hospitals, and medical centers. The Joint Commission for the Accreditation of Healthcare Organizations has been suggested as the appropriate regulatory body to require health care facilities to credential physicians performing fluoroscopy. Some hospitals already have educational programs on radiation safety for their physicians who perform fluoroscopy-guided procedures, and a few require periodic written examinations to maintain fluoroscopic privileges.

## Conclusion

Although relatively uncommon, radiation-induced skin injury is a significant complication of fluoroscopy-guided interventional procedures. Awareness of this potential complication has spurred advances in procedural techniques and fluoroscopic equipment design. With appropriate attention, radiation dose can be decreased by 75% or more. Most important, physicians performing interventional and cardiac catheterization procedures should be trained in radiation safety and techniques to reduce radiation exposure.

Julie K. Timins is a diagnostic radiologist practicing at Christ Hospital in Jersey City and

JFK Medical Center in Edison and in Morristown NJ. She is a past president of the Radiological Society of New Jersey, chair of the MSNJ Council on Communications, member of the MSNJ Council on Medical Services, and member of the New Jersey Commission on Radiation Protection. Jill A. Lipoti is the assistant director of radiation protection programs of the New Jersey Department of Environmental Protection and the Secretary of the New Jersey Commission on Radiation Protection.

## Acknowledgment

The authors thank Fred A. Mettler, Jr, MD, of the University of New Mexico School of Medicine, Albuquerque NM for providing the photographs in Figure 1.

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**MANDATORY EDUCATION  
ON RADIATION SAFETY  
AND THE APPROPRIATE  
USE OF FLUOROSCOPY HAS  
BEEN SUGGESTED,  
ALTHOUGH NO FEDERAL  
REGULATIONS EXIST.**

# Medicare's Evaluation and Management Codes

David L. Blecker, MD, MPH

There are very few changes this year in Medicare's evaluation and management (E&M) guidelines—the rules that apply to all patient nonsurgical encounters (e.g., office visits, hospital visits, consultations). Although the Health Care Financing Administration (HCFA) had indicated that a more user-friendly set of E&M rules would be forthcoming, there are no announced plans to modify these guidelines. This means that practices must concentrate on improving efficiency and learning to implement the regulations. The most important rule changes involve the redefinition of critical care time, clarification of the definition of a consultation, and screening for prostate and cervical cancers. Practices properly using the rules to bill for critical care time and consultations may realize a significant financial advantage.

## Critical Care

Critical care services have been redefined. In the past, critical care time could be billed when services were provided exclusively to one, critically ill, unstable patient for at least 31 minutes during a given day. As of this year, the patient may be stable (although critical), and critical care services may be billed when more than 30 minutes are devoted to the care of the patient. The physi-

cian/provider can bill for services at the bedside and time spent reviewing data, speaking with family members, or discussing the patient's care with other providers. The physician must remain at the nursing station or unit. If the visit is less than 30 minutes, the usual E&M codes should be used to reflect the work performed. For example, if a physician devotes 20 minutes to care for a critically ill established patient in the intensive care unit, codes 99231-99233 are used. When billing for critical care time, the physician needs to state the exact time during which services were provided, the specific duties performed, and their purpose. When billing for other E&M services unrelated to time, the physician must provide documentation of a history, physical, and decision. These are not required for critical care billing.

## Other Notes on Critical Care Billing

Only one physician may bill for critical care during a specific period of time.

If two physicians resuscitate a patient, only one physician may bill for critical care service; the other physician could bill for other services provided, including CPR, endotracheal intubation, and so forth. Because ICU patients frequently require the critical care services of multiple specialists,

providers must communicate to prevent contemporaneous billing.

The same rules apply for neonatal and adult critical care. With the exception of neonatal care, critical care time is cumulative during a 24-hour period (midnight to midnight). If 15 minutes were spent with a critically ill patient at 7 AM and an additional 15 minutes at 11 PM on the same date, the 30-minute total would be sufficient to allow for critical care billing. The total critical care time is rounded to the nearest half-hour. Code 99291 is used to report the first hour (actually, 30 through 74 minutes, because of rounding) of service on a given date. Code 99291 should be used only once per date. Code 99292 is used to report each additional 30 minutes of critical care services.

**Example 1.** Dr. A administered critical care service for a period of 132 minutes to a patient. She should bill 99291 for the first 60 minutes and 99292 twice to indicate that two additional periods of 30 minutes each were devoted to critical care. Rounded to the nearest half-hour, 132 minutes becomes 120, so the final 12 minutes will not be reimbursed. If Dr. A returns for another 10-minute period during the same day, total time would be 142 minutes (rounded to 150). A third 99292 would then be billed.



Critical care codes include the following services, which are bundled into the encounter when these codes are used:

- Interpretation of cardiac output measurement (93561, 93562).
- Interpretation of chest X rays (71010, 71020).
- Interpretation of blood gases (99090).
- Gastric intubation (91105).
- Temporary transcutaneous pacing (92953).
- Ventilator management (94656, 94657).
- Vascular access procedures (36000, 30415, 36600).

Occasionally, charging for bundled services will provide a higher payment to the physician than billing for critical care time. The physician is allowed to submit a bill that will result in the higher reimbursement. If any services not listed above are performed during critical care time, the amount of time spent for the service should be deducted and charged separately.

**Example 2.** Dr. A spent 120 minutes giving direct critical care service to a patient. Of these 120 minutes, 15 were spent inserting a transvenous pacemaker. Because placement of the pacemaker is not a bundled service in critical care, the practice should bill for 100 minutes of critical care time plus the pacemaker insertion. On the HCFA 1500 billing form, modifier 25 should be used to identify two separate services.

### Consultations

HCFA has defined consultations and more clearly differentiated them from referrals. This is impor-

tant, because Medicare payment for consultations is approximately 150% that of referrals. A referral is a request by one provider for another physician to assume care of the patient. The physician accepting a referral has agreed to treat the patient before an examination and evaluation. A consultation is a request for an opinion. A requesting provider expects a consultant to furnish an opinion and help formulate a treatment and diagnostic plan. HCFA has clearly stated that a consultant may evaluate and treat a patient. As long as the treatment decision is made after the evaluation, a consultation has been provided.

In the past, if treatment were provided, HCFA considered the encounter to be a referral (and reimbursed at a lower level). The new rules restrict the definition of a referral. To prove that an encounter is a referral, HCFA must prove that both the requesting and accepting providers had documented the transfer of care before the evalua-

tion and that there was a complete transfer of care.

Three key elements are required for a consultation:

- A request that states the purpose of the consultation. While a formal, written request is ideal, it is not required. If there is no formal request, documentation may be included by a notation in the record or in the letter sent to the provider who requested the evaluation.
- Examination and evaluation by the consultant.
- A written or printed opinion sent to the consulting provider or (for inpatients) placed on the patient chart.

**Example 3.** Dr. B, a nephrologist, agrees to take calls for Dr. C, a general practitioner. Mr. X develops abdominal pain and is sent by Dr. C's nurse to be treated by Dr. B. Dr. B has received a referral (even if the problem is related to the kidney), since the decision was made for him to treat the patient before the evaluation.

**Example 4.** Ms. Y is sent by her family practitioner to a cardiologist for evaluation and management of chest pain. If the cardiologist is asked to render an opinion and evaluate the pain, a consultation is performed. If the cardiologist is asked to treat the patient, it is a referral.

When requesting a consultation, physicians should be careful to ask for an evaluation only. If treatment is requested, HCFA can contend that that transaction is a referral. When writing a letter as a consultant, the practice should use lan-

**BECAUSE ICU PATIENTS  
FREQUENTLY REQUIRE  
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CONTEMPORANEOUS  
BILLING.**

guage such as "Thank you for sending Ms. Y to our office for our opinion," not "Thank you for referring Ms. Y to us." One member of a multispecialty group can obtain a consultation (or a referral) from another in a different specialty.

Consultations are billed with consultation codes 99241-5 (for outpatients) and 99251-5 (for inpatients). Referrals are not billed using these codes. For outpatient referrals, the initial outpatient visit codes 99201-5 should be used. If the patient has been treated in the past three years, the outpatient established codes 99211-5 should be used. Inpatient referrals must be billed using follow-up inpatient codes 99231-3.

## Screening Tests

Medicare has agreed to pay for screening examinations, including prostate and pelvic exams. Reimbursement, however, is minimal or nonexistent. Screening exams performed during an encounter otherwise covered by Medicare are considered part of the visit.

**Example 5.** An initial outpatient visit occurs for a 70-year-old female evaluated for cough. A screening pelvic exam is performed at the end of the level-3 (intermediate) visit. No additional Medicare billing or payment is allowed for the pelvic exam.

**Example 6.** A 66-year-old male established patient presents with hypertension. A history is taken and a physical is performed, including a screening prostate exam. Medicare is billed for a level-2 (limited) outpatient visit. No additional Medicare

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billing or payment for the prostate exam is allowed.

Medicare billing and payment for the pelvic or prostate examinations can be made only if they are performed as a distinct and separate service or as part of a routine physical examination.

**Example 7.** A patient is scheduled for a pelvic exam. No other service is scheduled. Medicare billing and payment are allowed.

**Example 8.** A 65-year-old male with no medical problems is scheduled for a routine screening physical, including a digital prostate examination. Because HCFA does not pay for a complete screening exam, the patient must sign a waiver agreeing to pay for any portions of the encounter not covered by Medicare. Medicare is billed for the screening prostate exam, with the patient responsible for the remainder of the visit. (The HCFA 1500 billing form should note that a complete physical exam was performed.)

Whether performed as a separate service (as in example 7) or as part of the complete physical exam (as in example 8), the reimbursement is the same as a minimal outpatient established visit (99211). The 99211 is typically performed by nurses with the physician (or other certified Medicare provider) available within the office. The new rules seem to encourage screening by a staff member rather than by a physician.

Prostate antigen tests are also being covered on a yearly basis. When billing for a screening test or examination, the practice should list the diagnosis or predisposition to disease. There are ICD-9 (diagnosis codes) that indicate both family and personal tendencies to disease. These diagnostic codes are preceded by the letter V. For example, for family history of cervical cancer the code is V76.2; for family history of prostate cancer the code is V10.46; for other screening the code is V76.44.

## Other Changes

There are a number of specialty-specific changes, most of which involve changes in the CPT codes for procedures. Virtually every subspecialty is affected. The greatest changes occur in codes for anesthesia, surgery, neurology, neurosurgery, and radiology. The CPT codes for many laparoscopic and endoscopic procedures have also been revised. Because specific changes are too numerous to list in this article, specialists should contact their subspecialty society.

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# Dr. Hugh Mercer

## Physician and Soldier

*Henry H. Sherk, MD*

The image of George Washington crossing the Delaware River on Christmas Day 1776 is familiar to every American, especially as a result of the famous painting by Emanuel Leutze showing the determined commander of the Continental army leading his troops in that desperate, last-ditch counterattack against the Hessians in Trenton. The attack was successful and changed the course of the Revolutionary War. Less well known, however, is that Washington had accepted the advice of a physician-turned-soldier in determining to proceed with the venture, and its success was largely due to that man's sagacity, courage, and total dedication to the cause of liberty—qualities that a few days later were to cost him his life. His name was Hugh Mercer.

Born in Aberdeen, Scotland in 1723, Mercer graduated from the Aberdeen University Medical School in 1744 and embarked on a medical career near his home. A year later he enlisted as a regimental surgeon in the army of Bonnie Prince Charlie to fight the English at the Battle of Culloden Moor. There, Scottish gallantry was no match for the methodical English, and the cause of Scottish freedom and the Stuart throne ended, seemingly forever, on April 6, 1746. Hugh Mercer, like all who served Charles Stuart, became a hunted man.

Fleeing Scotland, he sailed from Leith in March 1747 and arrived six weeks later in Philadelphia. After landing here, Mercer headed west; Philadelphia's Quaker culture was evidently distasteful to him, and he hoped to find more congenial company among the Scots and Scots-Irish who had migrated to the Pennsylvania frontier in the Appalachians. He set up his practice near what is now Mercersburg, where he remained for the next eight years. During that time, the French and Indian War increasingly affected life in western Pennsylvania, and in the spring of

1755, General Edward Braddock started his campaign against Fort Duquesne, hoping to end the war by securing the confluence of the Allegheny and Monongehela rivers for England. In July of that year, Braddock's army of almost 2,000 men met disaster. Braddock was killed, and hundreds of wounded soldiers straggled back to the forts on the Potomac River from which Braddock came.

Braddock's defeat had opened up the frontier to depredations by the French and Indians who roamed the countryside at will, burning farms and killing, kidnapping, and torturing the settlers in western Pennsylvania. In response, a newly organized Pennsylvania militia was ordered to build and serve at a chain of forts across the frontier. Mercer was given a commission as a captain in the militia on March 6, 1756. His medical education and military experience were thought to qualify him for the job, despite his lack of formal military training. Practical military experience was not long in coming. In September of the same year, Mercer's command was ordered to attack a large Indian stronghold on the Allegheny River, near Fort Duquesne. The attack was successful, and the Indians who were not killed were scattered, opening the way for a subsequent successful campaign against Fort Duquesne.

During the attack, Mercer was wounded, apparently sustaining an open fracture of his left arm. Worse, the Indians cut him off from the main body of his own men and he barely escaped capture. Injured, starving, and alone, without a hunting weapon, he struggled through the wilderness for 10 days to make it back to a provincial fort, where his wound was treated and his fracture healed. For the next two years, Mercer remained on duty as an officer in the Pennsylvania militia, participating in the successful campaigns that captured Fort Duquesne (rebuilt and renamed Fort Pitt and later Pittsburgh). This victory fin-



ally drove the French and Indians out of Pennsylvania. It was during these times of service he met and first established a friendship with George Washington.

With the end of the French and Indian War, Mercer was mustered out of the Pennsylvania militia in January 1761. By then, he was 35 years old, without a steady income and with no prospects for starting a family. Washington and others persuaded him that returning to his Pennsylvania practice would not provide him with the opportunity to achieve these goals and convinced him that he should settle in Fredricksburg, Virginia.

He remained in Fredricksburg for 15 years, "applying himself to the practice of physic" and did in fact achieve all that he had hoped for. He quickly developed a large practice, made many friends, and became an important member of the community. He married Isabella Gordon, the sister-in-law of a close friend and the daughter of John Gordon, who ran the town's largest and most popular inn. The Mercers had six children, the oldest of whom, Anna, eventually married Robert Patton. (The Pattons were

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direct forebears of General George Patton, who led American troops in WWII.) Mercer's investments turned out well. He bought land and secured a partner to invest in an apothecary shop adjacent to his office. (The shop still exists today and is a tourist attraction in Fredricksburg.)

It would be pleasant to leave Mercer there and at this point in his life, living happily ever after, honored and growing old peaceably and serenely. Such was not to be.

The Stamp Tax, the Townshend Acts, and finally the Tea Tax made it possible for such radicals as Samuel Adams and Patrick Henry to fan the spark of independence into a flame, arousing the people of the colonies into open revolt against Great Britain and its king. After the events at Concord and Lexington in April 1775, the Virginia House of Burgesses (which had changed its name to the Virginia Convention) requested Mercer to take command of the First Virginia Regiment. Remembering the British atrocities he had witnessed after Culloden 29 years earlier, he accepted. His organizational ability, command skills, and success in forestalling British landings in Virginia made him an obvious choice for promotion, and on the recommendation of George Washington, commander and chief of the army, John Hancock, president of the Congress, wrote to Mercer in 1776 as follows: "I am directed by Congress to inform you that they yesterday appointed you a Brigadier General in the Army of United Colonies. . ."

Mercer joined Washington's army at the beginning of one of the most disastrous campaigns of the war. The Americans were outnumbered and outmaneuvered. The British and their Hessian mercenaries drove the Continental soldiers out of New York and northern New Jersey. By late December 1776, the dwindling American force had retreated into Pennsylvania, abandoning New Jersey entirely, hoping against hope that Washington's pathetic remnant of an army might somehow block the British from walking across the Delaware, soon expected to freeze. Under these circumstances, the capture of Philadelphia, the capital city, might well end the Revolution. By Christmas 1776, General William Howe, the British commander, had troops in South Amboy, New



Figure 1. The Mercer County logo depicts the Mercer Oak in the foreground, beneath which Dr. Hugh Mercer received his mortal wounds in the Battle of Princeton. The oak tree stood in the Princeton Battlefield Park until March 3, 2000, when it finally fell to age and a winter storm.

Brunswick, Princeton, Pennington, Bordentown, Burlington, and Trenton.

Mercer realized that the only hope was a bold counter-stroke before the soldiers' enlistments ran out and the army disbanded. It was he who counseled the crossing and he who led the charge down River Road into Trenton to surprise the sleepy Hessians on Christmas morning. Four days later, the tables seemed turned when General Charles Cornwallis, having rapidly brought a major force down from New Brunswick, appeared to have the Continentals pinned against the Delaware just south of Trenton. He waited only for first light to complete the destruction of Washington's small force. Mercer again advised a counter-stroke, this time a silent midnight march out Quaker Road, south of the Assunpink Creek and around the sleeping British. By the morning of January 3, this had been successfully executed, and Cornwallis awoke to find the entire American army had disappeared.

By that time, the Americans were marching north along Stony Brook into Princeton, headed, they hoped, for the capture of the massive supply of military stores lightly guarded by a small British contingent in New Brunswick. The rear of the British army headed for the showdown at Trenton was marching down the main road from Princeton (today's Route 206) when they spotted Mercer's troops in the vanguard of the American army coming up Quaker Road (near what is now Mercer Street). The two armies met virtually head on, and the Battle of Princeton ensued. After the initial volleys, the Americans, who had rifles, not muskets, were slow to reload. (Rifles took longer to load properly.) The British line was among the American soldiers before another volley could be fired. The American rifles did not have bayonets, and, defenseless against the British bayonets and with empty weapons, the Continental line seemed on the point of disintegrating.

General Mercer unsheathed his sword and ran directly at the advancing British. He threw himself at the enemy, slashing in every direction, and refused calls to surrender. He was clubbed to the ground with the butt of a musket and bayoneted seven times. Mercer's single-handed assault seemed to stabilize the American line, which managed to regroup and stave off the British advance until reinforcements arrived. The British were eventually routed. Mercer was carried to a nearby house, where he died eight days

later, evidently from a deep wound in the axilla. The Continental army was saved and escaped to fight other battles and eventually win the War of Independence.

Although little remembered today, Mercer's heroism was well recognized in the earlier years of the American Republic. The US Congress voted to erect a monument to him. Towns, roads, and counties were named in his honor. In New Jersey, in the late 18th and early 19th centuries, the communities around the city of Trenton

MERCER JOINED  
WASHINGTON'S ARMY AT  
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OF THE MOST DISASTROUS  
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appealed to the New Jersey State Assembly to establish a new county from portions of Middlesex, Hunterdon, Somerset, and Burlington Counties. In 1838, Hudson County was created out of several adjoining counties in northern New Jersey, and to balance the political parties in the New Jersey Senate, the Assembly voted to create a new county with its county seat in Trenton. It was fitting that it

would be named after the fallen hero. The logo of Mercer County displays the Mercer Oak, the tree beneath which General Hugh Mercer, doctor-turned-soldier, fell on the field of battle. The tree stood for 223 years after Mercer's death, when it finally succumbed to age and a winter storm on March 3, 2000.

Henry H. Sherk is historian of the Camden County Medical Society; author of *Colleagues & Competitors: 150-year history of the Camden County Medical Society*; and professor of orthopaedic surgery, Medical College of Pennsylvania, Hahnemann University, Philadelphia PA.

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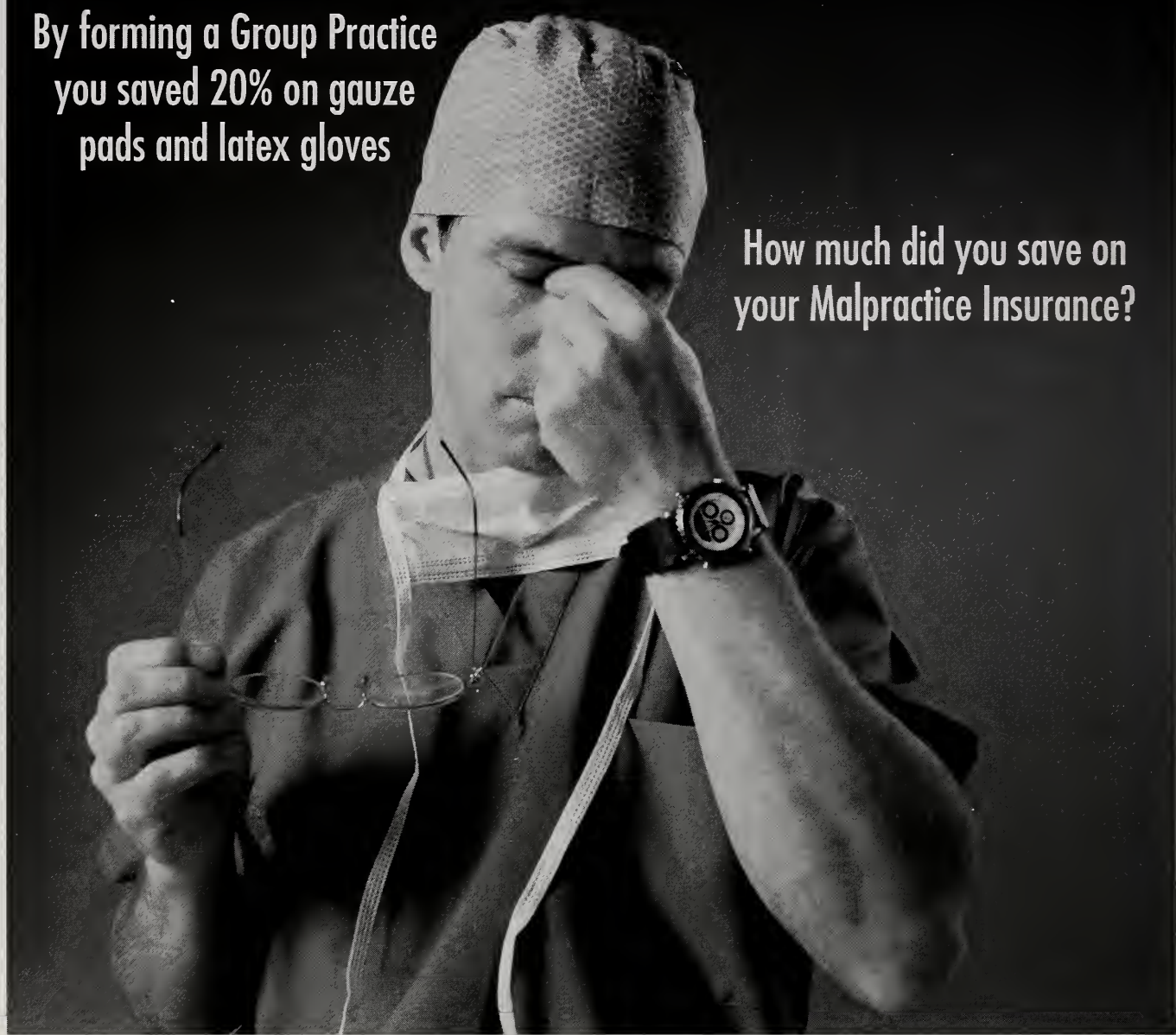
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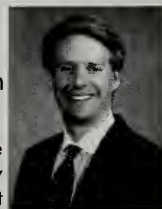
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# Senior Health Issues

THANKS TO IMPROVED LIVING CONDITIONS, BETTER NUTRITION, PREVENTIVE CARE, INCREASED FITNESS, ANTIBIOTICS, AND OTHER FACTORS, MORE AMERICANS WILL REMAIN HEALTHY THROUGH THEIR 80S AND BEYOND. AS PEOPLE LIVE LONGER, HOWEVER, SO DO THE DEMANDS FOR SERVICES AND PRODUCTS THAT RESPOND TO THEIR NEEDS. WILL THE MEDICAL FIELD BE PREPARED?

*Robin Rapport*

American society was unprepared for the revolution in age demographics. Even knowing that the birth rate increased dramatically after World War II, we were surprised by the high numbers of baby boomers entering grade school. We were shocked and unprepared when these children entered high school and college. Then, when they looked for jobs and began their young families, we had unexpected job and housing shortages. Now that the boomers are approaching their senior years, there is no reason to be unprepared yet again. Steps must be taken now to avert a potential crisis in health care.

Currently, 12% of the population in the United States is more than 65 years old. The rate in New Jersey is already higher. The number of elderly Americans is projected to double by the year 2030, reaching more than 70 million people. In New Jersey alone, the number of individuals older than age 65 is expected to exceed one million persons by July 2000. This will make New Jersey the ninth-highest-populated state in this age category.

"In the past century, the developed world has witnessed a greater increase in life expectancy than in all recorded history," reports Knight Steel, MD, UMDNJ-endowed professor of geriatrics at the New Jersey Medical School and chief of geriatrics, Director Home Care Institute, Hackensack University Medical Center. "The change in age demographics will have an incredible impact on society. The world will be very different. From a health standpoint, this segment requires the most care—both acute and chronic care." We are not prepared for the shifts that will take place.

## Rethinking Health Care for the Aged

There is a need for a new paradigm regarding health care for senior citizens. First, consider the fact that "65 is an arbitrary age . . . It does not represent a marked change in physiology. It represents a political decision," notes Steel.

Next, consider the changing trends in medicine and the needs of an aging population. In the 1950s and 1960s, with the introduction of antibiotics, new pharmaceuticals,

and improved surgery, the medical profession looked for and found "cures." A patient would come in with a chief complaint, and physicians would try to isolate it, find the cause, and cure the problem. "Today we need to get beyond that. An aging population accumulates chronic diseases. The goal is not a cure, but management over time," says Steel.

Similarly, Richard Murray, president and CEO, Kennedy Health Systems, believes that we need to take a new integrated and personalized approach to senior medicine. "The elderly have very specialized needs. We have given great credence to specialties in the past—but not to geriatric medicine. As the baby boomers age, more care will be needed for the elderly." Unfortunately, too few physicians receive geriatric training. This will be a serious problem in the near future.

"Goals must be made to ensure that the medical, emotional, and social needs of the elderly are continually being met, particularly as their situations change," adds Mike Dennis, vice-president, senior services, Kennedy Health Systems. "We



want to encourage solutions across the entire health care continuum."

Another goal should be keeping individuals happy, productive, active, and independent as long as possible. "We call this raising the frail line," says Dennis. This can be best achieved with a system of integrated, coordinated, preventive care. "The proper management of older persons is not simply the sum of all the specialists. You need an appropriate overview of the patient's total problems before you intervene," says Steel.

### A New Model

One example of an integrated system is the Kennedy Health System, a core teaching affiliate of UMDNJ. It recently spent more than \$8 million developing a new model to better accommodate individuals more than 65 years old in parts of Burlington, Camden, Gloucester, and Atlantic counties.

Kennedy's model spans the entire continuum of care, based on a multihospital system. It includes a gerontology center, personalized care management, a nursing home, residential facilities, membership clubs, and assisted-living facilities. It also includes community-based services (wellness, housing, legal, support, medical screenings, etc.), health centers at senior housing communities and apartment complexes, a behavioral health outpatient program, and a host of other services to facilitate independent living.

Although Kennedy's model and expansion have encountered some governmental obstacles, it remains dedicated "to handling care across

the entire health care continuum," says Murray. "We have devoted a great deal of our time and attention to this. We believe in the future of geriatric medicine."

### The Importance of Access and Support

While many other hospital and health care organizations are beginning to implement programs like Kennedy's, most individuals do not have access to a system of comprehensive, integrated senior care. Fortunately, in New Jersey, some help is available. The state has 21 substate agencies on aging dedicated to improve the quality of life and to support independence in seniors.

Nancy Day, director of the Office of Community Programs, Dept. of Health and Senior Services, recommends a helpful resource to physicians in New Jersey. "There is a new toll-free number, (877) 222-3737, for both physicians and patients. The call is automatically transferred to the appropriate county office that can help with a wide assortment of problems," says Day.

Physicians can use the number or give it to aging patients and their families who need assistance, outreach, case management, hospice, adult day care, meals, transportation to doctor appointments, or referrals

to other programs. For Medicare-related questions or problems, Day recommends calling (800) 792-8820.

It is imperative to help seniors get the support they need, early. "Without it," warns Dennis, "problems don't resolve early enough. The patient's condition deteriorates, and increasingly more chronic problems result. People end up calling 911 and living in hospitals or assisted-living situations sooner than they should."

### Conclusion

In the quest for maximum function and quality of life for the longest amount of time, changes must be made in the way we deliver care. Health care needs to be less fragmented and more person-specific. Prevention must be integrated into care for people of all ages.

According to Steel, because of the global nature of the problem, success can be achieved more rapidly by expanding our efforts internationally. He recommends worldwide "studies that highlight preventive health measures designed to reduce the incidence of chronic disease and functional disabilities."

In the meantime, it is important to recognize that the elderly are a group unto themselves and that specialized skills, training, and sensitivity is necessary for their care. In addition, resources and services must be shifted to accommodate the changing health care needs of this aging population. With advance preparation, this time we can be prepared for the baby boomers. ■

*Robin Rapport is a freelance writer based in Trenton.*

IN NEW JERSEY ALONE,  
THE NUMBER OF  
INDIVIDUALS OLDER THAN  
AGE 65 IS EXPECTED TO  
EXCEED ONE MILLION  
PERSONS BY JULY 2000.

# Osler: Inspirations from a Great Physician

Charles S. Bryan  
New York: Oxford University Press, 1997  
256 pp., \$39.95  
ISBN: 0195112512

The enduring interest in the career of Sir William Osler (1849-1919) would hardly be surprising to the generation of physicians who were trained by or influenced by his students. A century ago, when he was at the pinnacle of his career, he was one of the most famous physicians in the world. Osler was widely admired and beloved by the countless thousands of patients and health professionals whose lives he touched. Osler's legendary stature continued to rise even after his death, in part due to the massive, authorized, Pulitzer prize-winning biography by Harvey Cushing (1925), who had lived next door to Dr. and Mrs. Osler in Baltimore at one time and remained their close friend thereafter.

William Osler was born in a small rural town in upper Canada. After receiving his medical degree at McGill he was, in succession, professor of medicine at McGill, the University of Pennsylvania, Johns Hopkins University, and Oxford University. Osler first became famous for his eminently readable yet authoritative textbook, *The Principles and Practice of Medicine* (1892), which he wrote during his initial years as the first chairman of medicine at Hopkins. From an early age

he showed characteristics of personal ambition, intense self-control, a puckish sense of humor, and a high degree of sensitivity to the needs of others. He was also an incredibly prolific writer; Charles Bryan doubts that anyone has read all 1,500 or so of Osler's articles and addresses.

Interest in Osler's life was reawakened as the 150th anniversary of his birth approached, and many new interpretations of his life and work have appeared within the past three years. Bryan estimates that at least 1,200 articles about Osler have been published, including four major biographies (a fifth was published by Oxford in 1999). PubMed ([www.ncbi.nlm.nih.gov](http://www.ncbi.nlm.nih.gov)) lists 191 peer-reviewed articles about Osler, including 11 in 1999; even that list is incomplete, for I know of two others in 1999 alone.

Charles Bryan is a distinguished professor of medicine at the University of South Carolina and a noted contributor to what he calls the Osler industry. The four articles that he has published on Osler in the past four years demonstrate his wide-ranging interest and scholarship, covering Osler's contributions to infectious disease and humanism as well as his impact on the funding

of medical science by the Rockefeller Foundation. Believing, correctly, that another full biography of Osler was not needed at this time, Bryant focuses instead on eight aspects of Osler's life that he believes have relevance for us today. Bryant's essays on Osler are highly readable individually, yet they also flow in a logical sequence from first to last. He discusses in turn Osler's methods of time management, his emphasis on finding a calling and finding mentors, his positive thinking, his goal to "learn and teach," his compassion, his skills as a communicator, and his search for balance in "a simple and temperate life." Osler recommended that every physician develop a bedside library, and he personally read for an hour before retiring every night. Bryan's book would serve well as bedside reading for any physician, young or old. He obviously admires Osler, yet he does not hesitate to call attention to some of the flaws and paradoxes of Osler's persona—his ambition, his occasional flashes of anger, and his burnout late in life. In this brief but well-written collection of essays, Bryan brings Osler to life again; it is good reading and well worth the price.

George J. Hill, MD



**Allgair, William A., MD** March 10, 1922-January 29, 2000. Jefferson Medical College (1951), Middlesex County, General.

**Ambrosio, Michael, MD** February 11, 1929-March 18, 2000. University of Bologna Medical School (1959), Internal Medicine.

**Arboleda, Fe S., MD** August 18, 1943-January 12, 2000. University of the East (1969), Bergen County, Obstetrics/Gynecology.

**Balogh, William A., MD** August 19, 1909-January 2000. New York Homeopathic Medical (1935), Middlesex County, General.

**Barbano, Alfred J., MD** February 13, 1912-March 26, 2000. Temple University Medical School (1938), Middlesex County, Obstetrics/Gynecology.

**Bauer, William F., MD** November 2, 1922-February 15, 2000. Heidelberg (1948), Union County, General.

**Berkow, Bori, MD** September 2, 1977-March 17, 2000. New York University School of Medicine (1942), Middlesex County, General.

**Burke, William N., MD** February 14, 1927-January 27, 2000. New York Medical College (1953), Bergen County, Pediatrics.

**Charney, William, MD** April 14, 1910-January 31, 2000. University of Dublin (1935), Passaic County, Government.

**Chenkin, Theodore, MD** October 1, 1921-March 4, 2000. New York University (1949), Union County, Internal Medicine.

**D'Alonzo, Jr, Walter A., MD** December 11, 1954-January 24, 2000. Temple University (1980), Burlington County, Diagnostic Radiology.

**Doyle, Margaret H., MD** July 1, 1919-April 14, 2000. Long Island College of Medicine (1942), Morris County, Obstetrics/Gynecology.

**Farb, Harry H., MD** September 1, 1907-February 8, 2000. University of Berlin (1939), Essex County, Psychiatry.

**Fass, Edward, MD** June 28, 1944-March 5, 2000. CMDNJ Medical School (1978), Bergen County, Dermatology.

**Franklin, Joseph E., MD** November 30, 1904-February 2, 2000. Long Island College Hospital (1929), Union County, General Surgery.

**Gadon, Richard K., MD** October 1, 1955-March 29, 2000. Temple University Medical School (1982), Atlantic County, General Surgery.

**Giard, Henry L., MD** March 14, 1929-December 12, 1999. Tufts University (1956), Camden County, Radiology.

**Greeley, Joseph P., MD** February 28, 1922-January 5, 2000. Jefferson Medical College (1947), Union County, Pathology.

**Haut, Milton E., MD** July 26, 1911-January 29, 2000. Glasgow, Scotland (1941), Monmouth County, General.

**Hirshorn, Arthur E., MD** April 5, 1901-March 4, 2000. Hahnemann (1926), Camden County, General.

**Kornblum, Robert, MD** November 5, 1936-April 6, 2000. State University of New York-Downstate Medical Center (1962), Morris County, Pediatrics.

**Lipkowitz, Myron A., MD** April 12, 1938-March 19, 2000. University Autonoma de Guadalajara (1975), Monmouth County, Emergency Medicine.

**Ma, John Y., MD** December 29, 1918-December 26, 1999. National Medical College of Shanghai (1935), Middlesex County, Psychiatry.

**Nelson, Francis B., MD** July 25, 1913-February 1, 2000. Jefferson Medical College (1943), Union County, General.

**Reilly, William Duraind, MD** June 6, 1922-January 5, 2000. Hahnemann (1949), Monmouth County, Psychiatry.

**Salzman, Morris, MD** June 16, 1920-January 10, 2000. Indiana University (1943), Morris County, Obstetrics/Gynecology.

**Shier, Barbara, MD** July 13, 1915-December 11, 1999. Washington University Medical School (1945), Passaic County, Ophthalmology.

**Sussman, Leon N., MD** June 28, 1907-March 10, 2000. New York University School of Medicine (1932), Essex County, Immunohematology.

**Treanor, William J., MD** October 1, 1928-January 12, 2000. Marquette (1951), Morris County, Internal Medicine.

**Turner, Norman S., MD** November 13, 1932-February 13, 2000. Hahnemann (1959), Bergen County, Orthopedics.

**Wallack, Eli A., MD** October 7, 1908-April 8, 1999. Long Island College (1932), Hudson County, General.

## MSNJ ALLIANCE REPORT

One of the MSNJ Alliance's most successful statewide programs for more than 10 years has been an annual Teen Health Seminar. It is by far our most intensive outreach program and is so popular among schools that it has a waiting list for participants.

In order to address that problem, two seminars were held this year. The first was held in January in Lawrenceville. Approximately 160 high school students plus accompanying faculty attended. The second was held in March at the University of Medicine and Dentistry of New Jersey Stratford campus. Approximately 200 students plus 20 faculty members attended the program.

The sole purpose of the event is to bring teenagers together from all parts of New Jersey for a day of interesting educational programs about drinking and driving, substance abuse, date rape, violence in our society, eating disorders, tobacco-induced illnesses, and other health issues. It is intended to provide information that teens may use in making decisions that will influence, extend, or even save their lives. Invitations are sent to high school principals throughout the state. They in turn select 10 students and 1 faculty member to attend. The schools are accepted on a first-reservation basis, and the total number of students is restricted by the size and capabilities of the hosting facility.

The theme of the programs for this year was "Think Bright; Live Right." It addressed various substance abuses such as alcohol, drugs, inhalants, and steroids. Literature was distributed that addressed various health concerns that time did not permit to be discussed. Hot-line

phone numbers to be used for counseling and emergency assistance were also made available. As an additional bonus, small favors such as pens, buttons, and T-shirts emblazoned with "Think Bright; Live Right" were also distributed to each participant to commemorate the event.

Irving P. Ratner, MD, MSNJ president, and Gwen Jacobs, president of the MSNJ Alliance, opened both seminars with welcoming remarks.

Excellent speakers enhanced both seminars. Our keynote speaker, Michael Green, president of Collegiate Consultants on Drugs and Alcohol, has national recognition as an outstanding and charismatic leader who drives home the realities of a very serious topic in a very powerful way. He is a recovering alcoholic, a graduate of Villanova University, a former professional football player, and sports coach. The students received a very clear message from his presentation. He has presented almost every year, and students clamor to hear him.

Bryn Mawr Rehab Center also presented a program that focused on the results of drinking and driving. Executive Director Linda Cornwell presented two young people in their 20s who were the victims of drunk drivers. One actually was a drunk driver, and the other just an innocent passenger on her way to church Christmas Eve.

The New Jersey State Police Community Unit provided an interactive program using special goggles that simulate legal intoxication. Students were asked to carry out such simple tasks as catching a tennis ball, walking a taped line, and putting a cap on a ball point pen while wearing the goggles. Participants were astounded by their inability to perform these tasks.

Jeffrey A. Zlotnick, MD, spoke on "Sports Nutrition: Facts and Fiction," which dealt with the truth and myths of steroids, megavitamins, dietary enhancers, and sports beverages. His description of the side effects of steroid use was quite graphic and impressive.

Reverend Ed Reading gave an enlightening talk on inhalants, entitled "Huffing Your Way Into Oblivion." Teens often ignore the fact that this practice is potentially lethal.

The highlight of the second seminar at UMDNJ was undoubtedly the appearance of the governor of New Jersey, Christine Todd Whitman. The governor presented a program she is sponsoring entitled "V-Free." This addresses antiviolence, antivandalism, and antivictimization. She urged the students to take responsibility for themselves, their schools, and their communities.

The program concluded with a presentation by Ronald L. Kamm, MD, entitled "Teenage Sports Violence and Hazing." The subject of hazing and school violence was particularly timely with schools currently under careful scrutiny to safeguard their students.

The day was well received by the students and others who observed it. UMDNJ faculty members expressed their interest in our return next year and the possibility of including some appropriate programs with which they are currently involved.

This program is provided free of charge to the schools and depends on the funds raised entirely by the MSNJ Alliance. The Alliance solicits funds from pharmaceutical and insurance companies as well as responsive private individuals, merchants, and industry.

*Submitted by Gwen Jacobs, immediate past president, MSNJ Alliance.*



## PEOPLE IN THE NEWS



David I. Canavan, MD

David I. Canavan, MD, founding medical director of the Physicians' Health Program of the Medical Society of New Jersey, was honored at the 31st Annual Medical-Scientific Conference of the American Society of

Addiction Medicine in Chicago for his dedication and service to the public—physicians in particular—in the area of substance-abuse treatment.

Dr. Canavan has worked in the field of addiction medicine since 1955. For 27 years he was the medical director of Mt. Carmel Hospital, now known as Straight and Narrow, in Paterson where he was directly responsible for the treatment of more than 26,000 acutely intoxicated alcoholic men and women and approximately 5,000 drug addicts.

In 1982, Dr. Canavan became the first full-time medical director of a Physicians' Health Program in the United States. During his tenure at MSNJ, he developed the premier Physicians' Health Program, which is used as a model throughout the country to help physicians who suffer from the diseases of impairment.

Donna R. Pizzulli, vice president

for strategic information services for the New Jersey Hospital Association, received the New Jersey Healthcare Administrator of the Year award; Catherine Weglarz, information management librarian of UMDNJ, Robert Wood Johnson Library of the Health Sciences, received the New Jersey Health Sciences Librarian of the Year award. Both awards were presented by the Health Sciences Library Association of New Jersey.

David Sable, MD, director of the division of reproductive endocrinology and infertility at the Institute for Reproductive Medicine and Science of the Saint Barnabas Medical Center recently presented the keynote address at the annual symposium of the American Infertility Association.

The Valley Hospital recently honored six physicians for their contributions to the medical staff and the hospital. Testimonials were presented to retiring physicians Charles Hirsh, MD, Melvin Robbins, MD, and Frederick Steinberg, MD. Certificates of appreciation were presented to outgoing department directors Stephen Haggerty, MD, Joseph Lozito, MD, and Louis Rambler, MD.

Steven C. Fiske, MD, FACP, was elected first vice chair of the New Jersey Public Broadcasting Authority by its board of commissioners.

## 2000 INTERNATIONAL CONFERENCE ON PHYSICIAN HEALTH

The AMA and the Canadian Medical Association recently held the annual International Conference on Physician Health at Seabrook Island SC.

Presenting at this conference and representing the MSNJ, were Louis E. Baxter, Sr, MD, medical director of the Physicians' Health Program, and Edward G. Reading, MDiv, assistant director.

Rev. Reading was responsible for two workshops at the conference: Understanding and Assessing Spiritual Health in Clinical Practices and Integrating Impairment Issues into a Medical School Curriculum for Addiction Medicine.

Gregory Rokosz, DO, JD, president of the New Jersey State Board of Medical Examiners, and Dr. Baxter presented to a standing room-only audience on the topic of "Returning the Repaired Physician to Practice." They reviewed the development and management of the Alternate Resolution Program and how physicians are monitored through this program to ensure they are adequately treated while affording protection of the public.

## COLLABORATION FOR MENTAL HEALTH ADVOCACY

The New Jersey Hospital Association and the New Jersey Association of Mental Health Agencies have agreed to collaborate to create greater awareness of how mental health and physical health are both integral to sound well-being. Areas of collaboration include leg-

islative and public policy advocacy, information sharing, education, media relations, community events, and patient antistigma and antidiscrimination endeavors. For more information, call (609) 275-4071 or (732) 528-0900.

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If you visited [www.msnj.org](http://www.msnj.org) during March and April, you know that MSNJ kept you up to date on a daily basis on the progress of A-1890/S-1046, legislation that will restore to providers \$100 million of their pending claims against insurers HIP and APPP. MSNJ also provided phone numbers and e-mail addresses to help you contact your state assembly and senate representatives. If you send MSNJ your e-mail address, we will be able to notify you of important news being posted on the Web site, as well as provide you with other alerts.

You don't have to use your professional or personal e-mail address. There are a host of free, Web-based e-mail services on the Internet. Some of the largest are [www.hotmail.com](http://www.hotmail.com), [www.netscape.com](http://www.netscape.com), and [www.yahoo.com](http://www.yahoo.com), but many others exist. MSNJ's Web site will soon offer a special page for providing this information; in the meantime, if you send your name and e-mail address to [info@msnj.org](mailto:info@msnj.org), we will add it to the MSNJ E-News Service list.

## HEALTH CARE E-RECRUITING

An average US company spends from \$5K to \$50K on recruiting and

hiring a new employee. And according to the Federal Bureau of Labor, demand for a variety of health care positions is projected to grow through 2006. Finding highly skilled workers is one of the most critical issues facing health care organizations.

Online recruiting can lower the cost of traditional recruiting methods by as much as 50% and can shorten the length of a search by 50% to 75%. The popularity of general recruitment sites such as [Monster.com](http://Monster.com), [HotJobs.com](http://HotJobs.com), and [Headhunter.net](http://Headhunter.net) have proved that job seekers and employers alike are finding advantages in turning to the Web to speed up the process of finding the perfect match.

MiracleWorkers.com is dedicated to health care recruiting. It includes four components:

- A health care-specific Web site with job listings from across the nation.
- A marketing campaign to attract health care workers.
- An application service to power the recruiting section of an individual facility's Web site.
- Account managers to assist HR personnel in their recruiting efforts.

The system is available free of charge to job seekers, and employers can obtain a free three-month trial

with a 12-month subscription agreement. For more information, visit [www.miracleworkers.com](http://www.miracleworkers.com) or call (770) 246-0282.

## ONCOLOGY.COM AND CANCER411.ORG PARTNER TO PRODUCE LIVE CANCER CHAT EVENT PROGRAMS

Cancer411.org (<http://www.cancer411.org>) and Oncology.com (<http://www.oncology.com>), two online resources focused on the needs of the cancer community, announced that they will join forces to launch regularly scheduled live programs with guests including oncologists, researchers, integrative health practitioners, and cancer survivors.

The programs, which will be available through the Oncology.com and Cancer411.org Web sites, will bring together cancer patients and their families, as well as health care practitioners, to share many of the issues and challenges facing the cancer community. Participants can now send in their questions, comments, and concerns to live-event hosts, whereupon they will receive monitored live responses from survivors and leading professionals.

Topics to be discussed will include:

- Current cancer issues for patients,



their families, and health care practitioners.

- Clinical trial information.
- Patient resources.
- Complementary therapies.
- Side-effect management.
- Financial and legal issues.

Cancer4U.org and Oncology.com want to help expedite this development process by shortening the time it takes for cancer patients and their families to obtain the information they need by putting them into direct contact with

those who can report on and explain clinical trial results.

These live event interviews provide a forum for oncologists and other health practitioners to exchange treatment information. They will also conduct CME testing, as well as lectures, forums, and seminars using this chat technology.

The second phase of these chats will incorporate Web casting with live streaming audio and video, as well as PowerPoint slide presentations, Flash

animation, and Web site tours. A visitor will be able to tune into the programs, free of charge, like a radio show, and have questions answered directly. Transcripts of the events will also be available.

For a complete listing of the upcoming shows, available transcripts, and background information on the event guests, please check the event calendars on the Web sites or contact Susan Lee, (310) 630-1360 ext. 380, e-mail [susanl@c3live.com](mailto:susanl@c3live.com).

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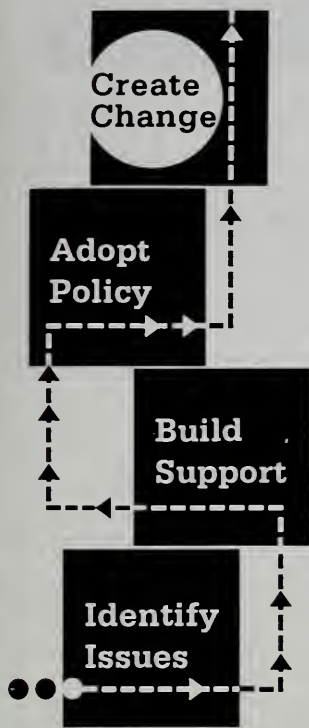
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## 2000 Annual Assembly Meeting June 8-12, in Chicago

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- **Identify issues** of critical importance to medical staffs, such as on-call emergency coverage and EMTALA guidelines, scope of practice, "exclusive credentialing," HCFA regulations, and medical errors;
- **Build support** for these issues through educational programs, special issue forums, state and regional caucuses, reference committee hearings, the OMSS Assembly, and the AMA House of Delegates; and
- Persuade the AMA to **adopt policy** that will further the needs and concerns of medical staffs; so as to
- **Create change** at various levels within the public and private sector in an effort to improve the quality and delivery of medical care and the professional and personal success of physicians

Elect a member of your medical staff to serve as an OMSS representative\* and attend the **2000 Annual AMA OMSS Assembly Meeting**. Topics for educational programs include:

- communication basics, team building and problem-solving
- on-call emergency coverage and EMTALA compliance
- scope of practice
- medical staff bylaws and the changing environment
- building "win-win" relationships between medical staffs and hospital/IDS administration
- status of legislative initiatives
- medical errors
- the impact of MCO insolvency on physician practice

For more information on how to register, call 800 262-3211 and ask for the Department of Organized Medical Staff Services or e-mail us at **omss@ama-assn.org**

\*Must be an AMA member

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|-----------------------------------------------------------------------------------------|------------|-------------------------------------------------------------------------------|
| <b>Nephrology Society Meeting</b>                                                       | June 20    | UMDNJ-Robert Wood Johnson Medical School,<br>New Brunswick NJ, (609) 275-1911 |
| <b>New Anticoagulants—Promises and Problems</b>                                         | June 20    | Jersey Shore Medical Center,<br>Neptune NJ, (432) 776-4420                    |
| <b>Tuberculosis 2000</b>                                                                | June 20-24 | The Roosevelt Hotel, New York NY,<br>(202) 737-3600                           |
| <b>Chronic Pain Management</b>                                                          | June 21    | St. Mary's Hospital, Passaic NJ,<br>AMNJ, (609) 275-1911                      |
| <b>Nanoscience and Nanotechnology:<br/>Shaping Biomedical Research</b>                  | June 25-26 | National Institutes of Health,<br>Bethesda MD, (240) 632-5618                 |
| <b>ASCRS Annual Meeting</b>                                                             | June 25-30 | Boston MA, (847) 290-9184                                                     |
| <b>1st International Conference on Vaccine<br/>Development and Immunotherapy in HIV</b> | June 28    | Palm Beach FL, (301) 496-5717                                                 |

**J u l y 2 0 0 0**

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|----------------------------------------------------------------------------------------|------------------|-----------------------------------------|
| <b>Annual Meeting of the American<br/>Orthopedic Society for Sports Medicine</b>       | July 2-5         | Washington DC, (847) 292-4900           |
| <b>34th National Immunization Conference</b>                                           | July 3-6         | Washington DC (404) 639-8225            |
| <b>International Conference on Alzheimer's<br/>and Related Disorders</b>               | July 9-14        | Washington DC, (312) 335-8700           |
| <b>13th International Symposium on Treatment<br/>of Leukemia, Lymphoma, and Cancer</b> | July 14-18       | New York NY, Imedex USA, (770) 751-7332 |
| <b>Update and Intensive Review in<br/>Internal Medicine</b>                            | July 30-August 5 | New York NY, (212) 781-5990             |

**A u g u s t 2 0 0 0**

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|---------------------------------------------------------------------------|--------------|-------------------------------|
| <b>Frontline Healthcare Worker Safety:<br/>Partnerships in Prevention</b> | August 6-8   | Washington DC, (678) 781-5241 |
| <b>Annual Meeting of the National Medical<br/>Association</b>             | August 12-15 | Washington DC, (202) 347-1895 |

**S e p t e m b e r 2 0 0 0**

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|------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------|
| <b>Current Topics in Health Care</b>                                         | September 13-14 | Atlantic City, (800) 940-5860                             |
| <b>American Association of Electrodiagnostic<br/>Medicine Annual Meeting</b> | September 13-16 | Philadelphia Marriott, Philadelphia PA,<br>(507) 288-0100 |

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|---------------------------------------------------------------------|------------------------|--------------------------------------------------------------------|
| <b>Certified Coding Specialist—Physician-based Exam</b>             | September 16           | American Health Information Management Association, (312) 233-1160 |
| <b>World Congress of Gynecology and Obstetrics</b>                  | September 17-22        | Washington DC, (514) 286-0855                                      |
| <b>New Developments in Retinal Disease and Vitreous Surgery</b>     | September 22           | Baltimore MD, (410) 328-5934                                       |
| <b>American College of Radiology Annual Meeting</b>                 | September 23-27        | New York Hilton & Towers, New York NY, (703) 716-7545              |
| <b>American College of Emergency Physicians Scientific Assembly</b> | September 28-October 8 | Philadelphia PA, (214) 550-0911                                    |

**O c t o b e r 2 0 0 0**

|                                                                                |                       |                                                     |
|--------------------------------------------------------------------------------|-----------------------|-----------------------------------------------------|
| <b>Clinical Endocrinology—Update 2000</b>                                      | October 1-4           | Philadelphia PA, (301) 941-0200                     |
| <b>American Society of Human Genetics</b>                                      | October 3-7           | Philadelphia PA, (301) 571-1825                     |
| <b>50th American Society of Bariatrics Physicians</b>                          | October 3-7           | Washington DC (303) 770-2526                        |
| <b>Lymphoma and Myeloma 2000</b>                                               | October 5-7           | New York NY, (770) 751-7332                         |
| <b>Seminar of Legal-Medical Issues</b>                                         | October 10-23         | Colonial Cruise departs New York NY, (800) 521-0076 |
| <b>1st International Geriatric Palliative Care Congress</b>                    | October 11-14         | New York NY (514) 286-0855                          |
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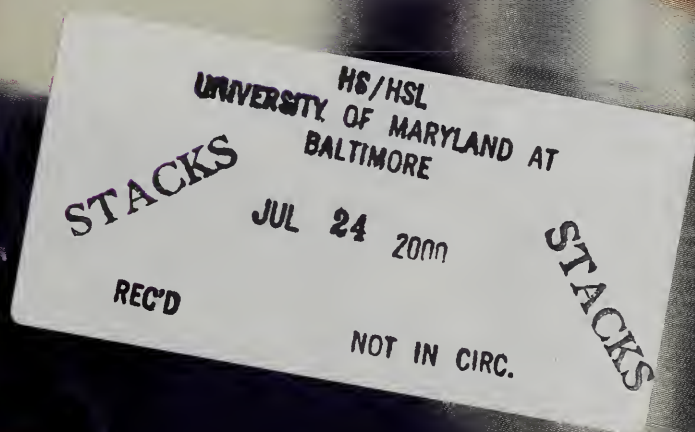


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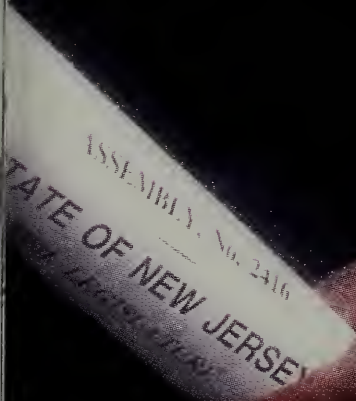
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## Medical myths and realities

Do you believe that Americans enjoy a relatively high life expectancy or visit physicians frequently, that health status is tied to the availability of specialty care, that employers care whether their health plan's performance garners poor ratings, or that there is no systematic way to decide which new medical technologies to reimburse? Get ready for new information.

**Spend, Spend.** Johns Hopkins Center for Hospital Finance & Management director Gerard Anderson and colleagues have published, in *Health Affairs*, the 1998 health spending figures for 23 of the industrialized member nations of the Organization for Economic Cooperation & Development. As always, the US ranked first in per-capita spending, at \$4,270. This was 72% higher than second-place Switzerland.

We were about average in physician visits per capita, at 6.0. And, of course, we were off the charts in

percentage of gross domestic product devoted to health care.

As *Medicine & Health Perspectives* points out, life expectancy in the United States is lower than the 23-nation average for both men and women. We are very high in potential years of life lost to preventable causes. We spend five times the average on hospital care per inpatient day. And it is primary care, not specialty care, that tracks with overall health status.

Dr. Anderson further reports that the United States has high fertility rates, only middling immigration rates, and low increases in life expectancy. Although these comparative findings do not reflect very highly on our system, they do position our country fairly well for the future. Other industrialized countries face much lower worker-for-beneficiary ratios, which means that very high percentages of workers' earnings must be appropriated to pay for the health and

welfare of elderly and other recipient groups.

**Cut, Cut.** HMOs no longer differ from other insurers in hospitalization rates. As of 1996, other carriers had cut their admissions to the same level as HMOs, report Agency

## Update on West Nile Virus

**T**here has been one confirmed isolation of West Nile virus from a crow found in River Edge, Bergen County in addition to two positive crows found in Rockland County, New York. Commissioner Grant reports that the CDC believes the crow found in New Jersey was newly infected. These findings increase the need for physicians to report suspected cases of viral encephalitis and presumptive aseptic meningitis in counties with confirmed West Nile virus activities (i.e., human, avian, or equine cases; positive mosquitoes). Reports should go immediately to the Department of Health and Senior Services (DHSS) at (609) 588-7500. Additional information on West Nile virus can be obtained at the DHSS website, [www.nj.us/health/](http://www.nj.us/health/).

for Healthcare Research & Quality researchers Robin M. Weinick and Joel W. Cohen, also in *Health Affairs*. Besides more aggressive utilization management by non-HMO plans, the trend may reflect the enrollment of more kinds of people in



HMOs, rather than just people who are relatively healthy.

The Health Care Financing Administration (HCFA) has proposed an algorithm for deciding whether to reimburse a new medical technology. A service would be paid if it is medically beneficial for a defined population and is a new clinical modality for a medical condition, is more beneficial than another reimbursed modality for the condition, or is not more expensive than the other modality. *Medicine & Health Perspectives* describes the approach (in excruciatingly more elaborate detail).

Commentators disagree about whether HCFA's approach emphasizes costs too much, too little, or at about the right amount. Call it the Goldilocks conundrum.

## Improvement Opportunities.

Medical group practices tend to be productive if they use registered nurses, standardize management practices, and tie physician compensation to productivity. Another advantage is to have physicians work four and a half or five days, instead of four days. These conclusions are reported by Lisa Scott, whose *Clinical Resource Management* article is abstracted in the *Healthcare Leadership Review*.

Eminent Rutgers University sociologist David Mechanic suggests that socioeconomic status and religion are determinants of health status. Both criteria typically are overlooked in the literature. Professor Mechanic writes in *Health Affairs*.

There, too, social researchers Mark Legnini and colleagues report that small-business persons place much higher weight on individual reactions than on research-based report cards when deciding whether to renew their health plans.

On the whole, the business owners' opinions, expressed in focus groups in Baltimore and San Jose, were that quality did not matter much when they were selecting a health plan. Cost and network concerns were considered more important. The Legnini team proposes more education about quality measures and stronger quality-related roles for regulators and professional organizations.

What is the impact of a policy requiring, without penalty, the reporting of medical errors? A hospital in Wisconsin saw its weekly medication error rate soar from 2 to 82. A report on the

experience is summarized in the *Healthcare Leadership Review*.

Summarized in the same issue is an article by Alan Joch that suggests that the promise of disease management may be revived through Web-based systems that can be implemented quickly and can tailor information for individual patients. Disease management is used for chronic diseases, which account for 70% of health expenditures.

**Respiratory Issues.** "War on Asthma" should be declared by the Surgeon General, asserts the Pew Environmental Health Commission. Under current trends, prevalence of this chronic disease could increase more than 50%, to 22 million Americans, in the next 10 years. *Medicine & Health* highlights the Pew Commission report.

How can physicians convince smokers to quit? The *Healthcare Leadership Review* reports a study finding that almost one-fourth of smokers decided to quit and another fourth decided to cut back after seeing computerized tomography (CT) scans of their lungs. CT can detect small lung cancers, for which the survival rate is 80%, and can detect nodules as well as tumors.

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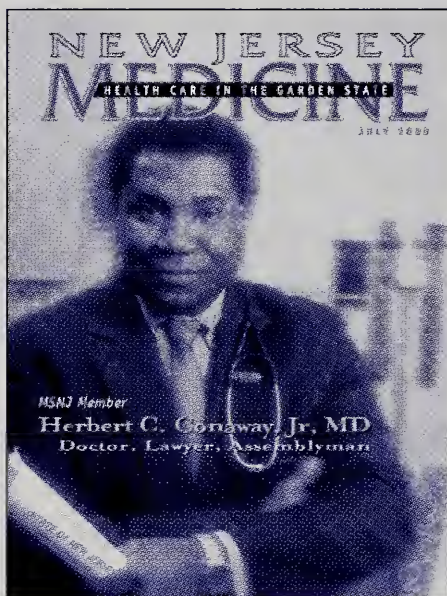
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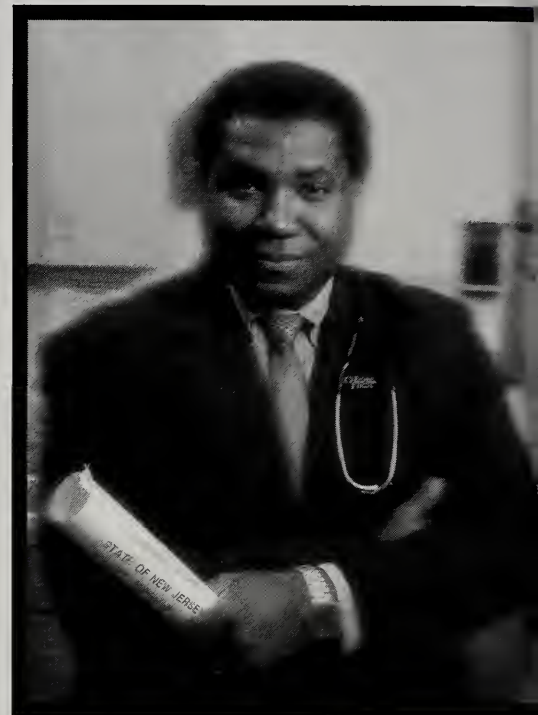
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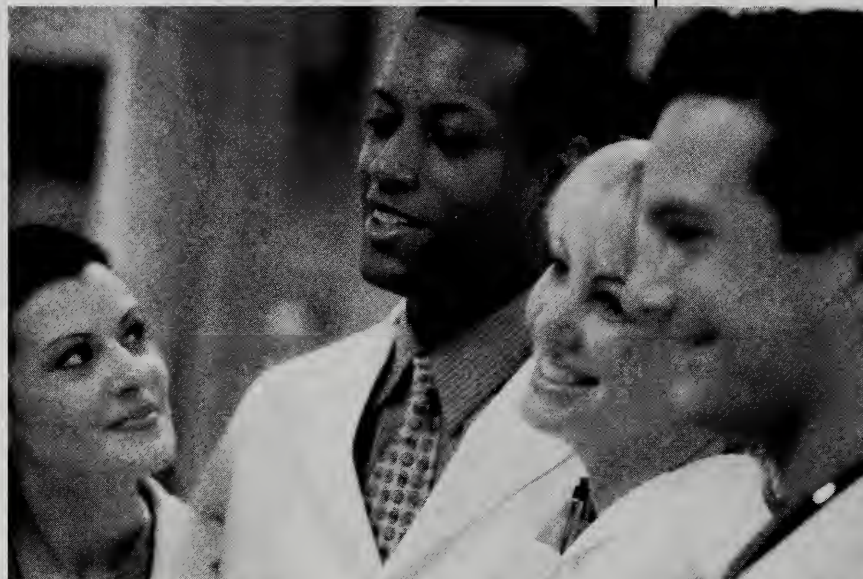
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## A DOCTOR IN THE LEGISLATURE

Only one physician serves among the 120 members of New Jersey's legislature. He is Herbert Clark Conaway, Jr, MD, assemblyman from the 7th legislative district in Burlington County.

Look again at the first sentence. Ten years ago we could have started this piece the same way. Back then, Harold Colburn, MD, also from Burlington County, was the legislature's only physician.

There are obvious differences between the two, but there's also a common thread. Dr. Conaway is younger, a Democrat, an African American whose first bid for public office was his successful candidacy in 1997 for the legislature. Dr. Colburn is older, white, a Republican, and a founding member of our federal political action committee JEMPAC, who served for years as a freeholder before his campaign for a seat in the General Assembly. The common thread? Also obvious: not only are both from Burlington and members of MSNJ, but both display(ed) an enormous dedication to the proposition that physicians ought to dedicate themselves to the public good—no matter what the sacrifice to their medical practice.

In a sense, both are a throwback to the earliest days of our nation, when physicians took a leading role in our breaking away from the British to establish our own government.

No one appreciates this fact more than Dr. Conaway. He majored in political science, not chemistry, not physics, not any of the sciences in his undergraduate studies. (He also earned a JD after his MD, but that's another story.)

We first met Dr. Conaway in July 1997, right after his primary campaign for the Democratic nomination for the General Assembly. Friends told us that a physician was a

candidate for the legislature. "Who, where?" we stammered, then made a dinner date, and then concluded "this guy has a real chance."

We did what we could to promote his candidacy. MedAC, our state political action committee, supported him, as did several of our more generous members, and he won—by 124 votes, earning him our nickname of "Landslide Conaway."

We were much better prepared for his reelection campaign last year. We vetted him to county medical societies (Mercer "adopted" him not only because he's a Princeton graduate, but more because his mother was for years a charge nurse in Trenton's St. Francis Hospital), specialty societies, the Physicians Club of Essex County, you name it. We formed our own Physicians for Dr. Conaway Committee and raised at least seven times more in contributions than we did two years before. The result: he won by a 5,000-vote margin. So much for "Landslide!"

Although we thought we knew Dr. Conaway pretty well when we interviewed him, *New Jersey Medicine* learned something new: here's a man who planned his life to prepare for public service. Thus the JD. He was no "accidental" candidate back in 1997 after all.

Our Physicians Conference in Atlantic City in May carried the theme of "unity." MSNJ and more than 35 specialty societies met under the same roof to explore what we have in common. There is no one who more exemplifies what we have in common than this vigorous young physician legislator who has just finished his residency in internal medicine. We know that you will enjoy this interview as much as we did.

*Clark Martin*

## THE SUPREME COURT AND SUITS AGAINST HMOs

The Supreme Court has unanimously ruled that financial incentives to physicians, used by HMOs to help control costs, do not make the HMOs liable to suit in the federal courts.

The case under consideration by the Court involved a delay in diagnostic testing for a woman whose appendix ruptured after she was forced to wait eight days for a test. The patient had already won an award in a malpractice case against the physician.

The Supreme Court defined the issue before it, in its written decision: "The question in this case is whether treatment decisions made by a health maintenance organization, acting through its physician employees, are fiduciary acts within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA)." The relatively narrow basis of the Court's decision related only to whether the patient could sue her HMO for not meeting its fiduciary responsibility under ERISA, to act in the interest of the participants and beneficiaries.

Congressional action, not precluded by the court decision, may be required to alleviate some abuses or potential abuses that have emerged in the new and developing environment of medical care.

In the meantime, the final responsibility for the quality of patient care resides, in most instances, where it has always been—in the hands of the physician. That is important for the medical profession as well as for those under our care. Regardless of whatever incentives a managed care contract may include to induce physicians to ration or limit care, and even though the New Jersey Supreme Court has ruled that an HMO may be held accountable if and when the HMO's policies or decisions have restricted a physician from providing appropriate care, ultimately the physician must make the best possible medical decision for the individual patient. The physician must also be that patient's advocate in obtaining the necessary care, treatment, or test. In this world of managed care, the physician's responsibility is greater than ever. *Paul J. Hirsch, MD, and Vincent A. Maressa*



## CHRISTINE GRANT'S GOALS

Christine Grant, the commissioner of the Department of Health and Senior Services (DHSS) possesses the qualities of leadership needed to bring public policy and regulation to the health care arena, which in our state continues to adjust to a changing health care delivery system.

For those who missed her Academy of Medicine address at the Physicians Conference 2000, it is printed in this issue of *New Jersey Medicine*. The outstanding accomplishments of the NJ DHSS under Ms. Grant's leadership reflect expertise and ability to work within government with partners from the constituencies that the DHSS serves. MSNJ is one of the most important of these partners.

Christine Grant's curriculum vitae will tell you that she has an MBA from The Wharton School and a JD degree from Rutgers Law School, that she has worked for the Robert Wood Johnson Foundation, and that she gained experience in the pharmaceutical industry by working for Merck and Connaught. But what her CV will not tell you is that she is very knowledgeable about vaccines and testified before congressional committees and advised federal agencies on the need for immunization. Her CV will not reveal that she knows that some community-based organizations need funds to provide services to individuals who never make it into the organized system of care and that to find children who are hard to reach and bring them into the

health care system, extraordinary measures, such as door-to-door outreach, are necessary.

When Christine Grant served as deputy commissioner for the DHSS, she fashioned the department's division of AIDS prevention and control. This occurred when the nation and New Jersey were just becoming aware of how significant an impact AIDS would have. New Jersey was one of the first states to recognize that health departments needed the appropriate organization to deal with this disease. In a similar fashion, Ms. Grant made tobacco control one of her priorities when she was appointed commissioner in 1999. She quickly set up processes to work effectively within her administration so that New Jersey's program could be a model for the nation as the tobacco settlement funds are being distributed. Commissioner Grant wants hospitals, laboratories, physicians, health departments, and other providers to use electronic technology to simplify reporting systems. The Web makes it more efficient and easier for providers to report findings and encounters, such as immunizations or childhood lead levels, to the DHSS. Using the Web will improve communications between the DHSS and the medical community, an important goal that deserves the support of the entire health care community.

*Leah Z. Ziskin, MD, MS*

## MEDICARE AND CLINICAL TRIALS

It is essential that clinical trials of new medications and new treatments include a broad and representative population of patients, if the studies are to be meaningful and accurately project expected results when the drug or treatment is released for use by its intended population group.

That does not always occur. Some groups (e.g., women, children, and the elderly) are underrepresented in many studies. We had the opportunity to discuss this issue in our *New Jersey Medicine* interview with President Harold Shapiro of Princeton University, who is also chairman of the National Bioethics Advisory Commission, last month.

Now, President Clinton has issued an executive order requiring that Medicare help pay the bills for seniors who participate in clinical trials. This change had been recommended by the Institute of Medicine and is essential if those in this age bracket are to play a proportional role in these studies.

In the past, Medicare has not covered treatment given in the context of a clinical trial, and many of the elderly have been reluctant to participate. This has presented a difficulty for virtually any study of a new drug. It has been a particular problem for certain classes of medication, for which the elderly are likely to make up a very large proportion of the expected patients.

Those older than 65 make up more than 60% of cancer patients but constitute only about one-third of those in the studies of new treatments for cancer. Many believe that this has delayed advances in cancer treatment. The new policy should help to alleviate this problem.

It now remains to be seen whether private insurance carriers will follow suit and routinely provide coverage for participation in clinical trials.

*Paul J. Hirsch, MD*



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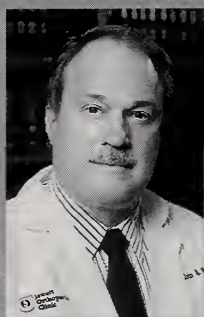
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*Walter J. Kahn, MD*  
*President, Medical Society of New Jersey*

**T**his sounds like a common sentiment from a physician colleague. Actually, it is a quote from Governor Christie Whitman in her address to the first New Jersey Physicians Conference this past May at the Atlantic City Convention Center. In addition to the governor, we heard from Christine Grant, our energetic commissioner of the Department of Health and Senior Services, and from US Congressman Greg Ganske, a principal of the federal Patients' Rights Bill and cosponsor of the Campbell Antitrust bill.

Surely these political highlights would have been enough for one conference. Yet we also hosted Senator Jack Sinagra and the entire New Jersey Senate Health Committee for an open hearing on the state action doctrine. Physicians gave direct testimony on the need for this legislation, which would give us the ability to collectively negotiate with insurers on behalf of our patients.

The conference offered more than politics and public affairs. More than 30 specialty societies joined in the conference planning. The Academy of Medicine of New Jersey

provided 17 CME credits through more than 80 educational workshops and sessions, including great programming for medical office staff. Our House of Delegates engendered a lively discussion on mandatory involvement in uncompensated care. And 160 vendors formed the centerpiece of a large exhibit hall, making this one of the largest, most comprehensive medical conferences in the Northeast.

Some people thought that it was risky to change our annual meeting into the Physicians Conference. Actually, maintaining the status quo would have been too risky in our efforts to effect the type of changes that New Jersey physicians need.

With a total of nearly 2,000 attendees, the conference exceeded our expectations. One sure sign of success: a primary drawback for attendees was having to choose from too many great events.

So set aside the dates of April 20-22, 2001, when we build on our success at Physicians Conference 2001. I look forward to seeing you there.



# Herbert C. Conaway, Jr, MD

*MSNJ Member in the  
New Jersey Assembly*



**H**erbert C. Conaway, Jr, MD, an assemblyman from the 7th legislative district, is the only physician in the New Jersey legislature. His district, which he is serving for a second term, includes parts of Burlington and Camden counties.

In the assembly, Dr. Conaway serves on the Health Committee and on the Agriculture and Natural Resources Committee. He is a strong advocate for health care and health policy issues, including prompt-payment legislation, HMO liability measures, increasing funding for charity care, and prescription assistance for seniors. He also has demonstrated a broad array of other interests, including economic development, consumer protection, property tax relief, and improving the educational system.

Dr. Conaway has an undergraduate degree in political science from Princeton University and is a graduate of Jefferson Medical College in Philadelphia. Subsequent to receiving his medical degree, he earned a law degree at Rutgers Law School-Camden. He has also served as a captain in the United States Air Force medical corps.

He is proud of his membership in the Medical Society of New Jersey, has attended the annual meetings of the society for several years, and frequently attends meetings of the society's Board of Trustees. He has also met with many

county medical societies and other physician groups.

*New Jersey Medicine*, represented by Executive Director Vincent A. Maressa, Legislative Representative Clark Martin, and Editor Paul J. Hirsch, MD, interviewed Dr. Conaway at the offices of Martin-Bontempo in Trenton. We found him to be thoughtful, knowledgeable, and well informed and concerned about health care issues that affect his profession, his patients, and his constituents. He emphasizes that physicians must participate in the legislative and regulatory processes to produce policy outcomes that are beneficial to our patients.

**New Jersey Medicine:** Dr. Conaway, you are the only physician in the New Jersey legislature. Do your colleagues look to you for advice on medical and health issues?

**Dr. Conaway:** I think that they do. The legislature is an amalgam of people who come from various backgrounds. In the legislature we must deal with a wide range of issues, and each of us brings experience from the broader society. When medical issues come up, my colleagues often take a moment to ask me about the views of the medical community. And this tends to be bipartisan. What I have found is that most of the good things that are done in the legislature are done on a bipartisan basis. Certainly, medicine itself is not a partisan activity. Our issues are patient-centered and grow from what is best for patients and for health care in New Jersey.

**NJM:** Could you tell us how or why you became interested in politics?

**Dr. Conaway:** I have had an interest in public service since my elementary school days. Throughout my education, I consciously prepared myself to enter public service by having a broad background and gaining experience in student government. It was for this reason that I majored in political science in college, while fulfilling all of my premedical requirements. I went to law school after completing medical school to prepare myself for public service.

I have always believed that a lot of good things can be accomplished for society when people involve themselves in the political life of their community at every level of government.

**NJM:** Isn't it unusual for a premed student to major in areas outside science in college?

**Dr. Conaway:** A large number of my premedical classmates in college majored outside science, in history

or politics. Our advisors stressed that it was not necessary to major in a science to go to medical school. Some of us felt that we would be dealing with the sciences for the rest of our professional lives and preferred to take the opportunity to learn about other things while we had the time and the chance.

Many of my college friends are now quite conservative, and I am often the lone Democrat in our discussions. One friend recently argued that government should act like a business and make quick decisions driven by the bottom line. I responded that government really cannot act in that way. Most governmental processes probably ought to run slowly. Making decisions in a way that would seem hasty or precipitous would erode the trust in government. Everything must be fully vetted, so that people can have confidence in the decisions of government. Governmental decision-making must be exposed to the light of day and open to public review. Without that kind of an open process, people could easily and understandably conclude that those decisions were based on something other than merit.

And of course, government must have concerns in addition to the bottom line. We are a society of people. There must be some concern about the effect that governmental policies have on individuals, on families, on where they live, and on what they do. Looking at life from a bottom-line perspective just doesn't work for government.

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GAINING EXPERIENCE IN  
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**NJM:** Has your experience as a legislator led you to believe that we need more physicians in government? Have you tried to encourage other physicians to participate?

**Dr. Conaway:** I've met with physicians around our state and have always encouraged them to be involved with every aspect of government affairs, especially as it relates to health care. Our involvement is important in making sure that policy outcomes are favorable to our patients and our profession. I urge physicians to contact their legislators regarding issues that are important to them, and I assure them that it does have an impact. I also encourage them to serve in elective office, if they have the time and willingness to do so. Certainly other professions are well represented in the legislature: the legal profession, business owners, and others. They are able to influence legislation from within the system, and physicians ought to do that as well.

**NJM:** If they succeed, will they have to spend much of their time on nonmedical issues?

**Dr. Conaway:** You cannot be a one-issue legislator, and that is not what I have done in the legislature. I have tackled issues from prescription benefits for seniors, to educational improvement, to school violence, to protecting our neighborhoods from guns and crime—it is necessary to be involved with the full gamut of issues to be effective.

Health care issues are helped when legislators from other professions find that a particular problem

HEALTH CARE ISSUES ARE  
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PRESCRIPTION DRUGS FOR  
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has hit home—for example, a legislator with an aging parent will become very aware of the costs of prescription drugs for the elderly. The issue of parity for mental health in insurance coverage was addressed because key people were affected in their families. And that is one of the reasons that you need a congress and legislature drawn from a broad range of the public, so that issues come to the attention of people who are involved, who understand problems, and who can make decisions based on what is right.

**NJM:** What is the status of the joint negotiations bill, which would give physicians the opportunity to collectively negotiate with managed care companies?

**Dr. Conaway:** Versions of this have been introduced into both houses of the legislature. The senate

version of this bill has been heard by the senate health committee. In the assembly, we are awaiting committee hearings.

I think that the principal effect that this would have would be to change the behavior of health insurers in the marketplace. If done well, this legislation would put patients and physicians on a level playing field with health insurers and HMOs. The big problem that health professionals have now is that the service contracts are presented as a fait accompli. Indeed, some have claimed that there is a difference between what HMOs have advertised to the public and what actually happens in the way that they operate and the rules that they apply to the provision of health care. Patients and physicians can work together to change some of those rules to make sure that if patients have problems their physicians will determine the course of their care. Joint negotiations can bring that about.

There are other important things that it can do. A lot of the contractual arrangements between physicians and HMOs have onerous provisions that are damaging to the ability of physicians to maintain their practices. Many physicians have found that they must add employees simply to manage their relationship with HMOs. Many contracts add to the workload and overhead of physician offices in ways that add nothing to the quality of care for our patients. If HMOs want certain record keeping done and certain information provided by the office,

they ought to pay for it; now, the physician pays for that.

Another problem that occurs is when a physician decides to refuse to limit care or to refuse to perform some of the duties that really are not pertinent to good patient care and the HMO will not sign a contract with that physician. There is an element of threat that the physician faces every time one of these contracts comes up for consideration. If physicians could come together to negotiate, those kinds of burdens could be removed from contracts. Currently, physicians are faced with a choice of accepting a contract or perhaps losing a significant part of their practice. Most people would say that that arrangement is unfair and would support this effort on behalf of the medical profession.

Americans have a fundamental characteristic—it is part of our cultural ethic—that prizes fairness. Americans can tell unfairness when they see it. They have a sense of when people are forced to do things and when they come to an agreement after negotiation between equals. The relationship between health insurers and physicians today is not equal, and it therefore runs fundamentally against a basic principle that Americans hold dear.

**NJM:** Another current issue relates to pain and pain management. Legislation has been proposed that would make the evaluation of pain in hospital and nursing home patients a so-called “fifth vital sign.” Many physicians are concerned that this is not truly a “vital

sign” and it cannot be measured objectively.

**Dr. Conaway:** I am less concerned with the terminology than the fact that there must be an assessment and a recording of this in some way. I would call it a pain assessment index or measure. We should thank Assemblywoman Charlotte Vanderwalk, the chairwoman of the Assembly Health Committee, for her leadership on this very important issue.

**NJM:** Reimbursement for charity care given by hospitals has been a major issue in New Jersey for 25 years. Because of the pressures of managed care, it has increasingly been an issue for physicians, also. What is happening in the legislature with this?

**Dr. Conaway:** Enlightened government leaders will have to take this bull by the horns. The issue is framed by the current national and state environment. Medicare reimbursements to hospitals have been cut at the federal level. The HMOs have done everything they can not to pay for care that has been rendered to their beneficiaries in hospitals. These two factors have placed tremendous pressure on legislators

to address the fact that there is not enough money in the health care system to provide care for those who need it.

We have about 1.3 million people in New Jersey who are uninsured. These people from time to time end up in the hospital. They receive care at the hospital. We, as health care providers, tend to worry about the money later, because our duty to the patient is paramount. It is time for the government to step up and to fulfill its duty, and that is to make sure that this care is reimbursed.

We live in a world of scarcity, and getting additional revenue, moving revenue from one line item to another, can be a problem. In addition, there have been differences of opinion among hospitals regarding a fair formula for charity care. Hospitals in the inner cities, where there are a lot of folks who do not have insurance, argue that they provide the bulk of the care and the formula should be tilted toward them. Hospitals that are not in the inner city but still provide substantial amounts of charity care argue that skewing the charity care reimbursement formula too far to the inner-city hospitals hurts their ability to perform their mission.

These problems would be less acute, less difficult, and less contentious if an appropriate amount of money from general revenue were put into the charity care system.

**NJM:** Wouldn't it be necessary to use a two-pronged approach: the state government probably should put money in from the general trea-

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sury, and all payors, including HMOs, ought to be required to pay a percentage of the reimbursement rate toward uninsured coverage, to spread the costs among what once was a fairly well-run system in New Jersey?

**Dr. Conaway:** I think that there is some wisdom in that. Costs are currently being spread to hospitals and physicians, to the providers of health care, and they share in the costs of unreimbursed care. The HMOs have managed to insulate themselves from that. As participants in the system, I think they have a responsibility to help in this area. Their own business model often shows that they are not in the business of doing all that they can to provide insurance for people who need it. They have benefited by the fact that there are a lot of people for whom they do not need to provide care. It is therefore only appropriate that they share in the burden of charity care in the state of New Jersey.

**NJM:** As a legislator, do you believe that hospitals, at least those that are 501 (C) (3), ought to have a component of charity care for which they are not reimbursed because they receive certain tax benefits?

**Dr. Conaway:** I agree. There could be no better way for non-profit hospitals to use those charitable assets than to provide health care for those who otherwise could not afford it, who do not have health insurance to cover their hospital costs. It is appropriate that all the players—hospitals, physicians, in-

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surers, and the state—share this burden. Right now, the state is not contributing its fair share, the HMOs are not contributing their fair share, and the providers are. That is dangerous and threatening to the continued survival of the system.

The average person thinking about this issue is wondering, "Is my local hospital going to be able to afford to remain open? What will it mean to me and my family if my local hospital has to close?" Charity care reimbursement is an important component of whether or not that hospital will be able to remain open.

**NJM:** But aren't there too many hospitals in New Jersey?

**Dr. Conaway:** There are probably surplus hospital beds in New Jersey. But we also have the second oldest population in the nation. A high percentage of our population base is the elderly, and generally the elderly have a relatively high utilization rate of hospital care and of the health care system in general. If we are compared with states that have a small percentage of the elderly, it is

not quite comparing apples to apples. So, if we have a few more hospital beds per person than other states, I think that is reasonable given the age of our population. If we have more hospital days per patient, I think that is also reasonable. My criticism of some of the reports that have come out is that they do not appropriately take our demographics into account.

I do agree that we have too many beds in some areas, which is why I have long been an advocate of allowing hospitals to get into other product lines. We must change regulations and aid hospitals in providing additional services such as assisted-living or skilled nursing facilities in the communities in addition to acute care.

Rather than seeing wholesale consolidation and closing of hospitals, we should deregulate and allow hospitals to have new revenue streams that will help them to stay healthy and provide vitally needed services and maintain jobs in their particular communities.

**NJM:** Do you think that some hospitals may be so critical to their geographic areas that they need to be supported whether or not they have the administrative and managerial ability to sufficiently diversify and improve their income streams?

**Dr. Conaway:** That speaks to the question of how the state manages downsizing of the hospital industry. There is no question that a top priority in that process must be the maintenance of critical services in certain areas. We cannot have people

bereft of access to acute-care hospital services when they need them. And remember that hospitals provide many services to their communities other than acute care and the provision of hospital beds. The jobs provided by that hospital might be important to the livelihood of the community. We must have a measured approach that takes into account access and jobs.

I believe that a component of that process will be to allow diversification. The hospital boards and managers will have to meet that challenge to survive. That is appropriate, because we apply that same model to every other industry, even to the way that physicians practice. We have had to change, for example, to rely more on outpatient services. Hospitals will have to do the same thing, in their own way.

**NJM:** As you have pointed out, a large proportion of our hospitalized patients are seniors, and they are predominantly "federal patients" on Medicare or Medicaid. The federal government has shown a reluctance to shoulder the responsibility for uninsured patients and actually continues to decrease the reimbursement for those patients that it does pay for. Certainly, there must be a general gathering of all parties with an interest to secure an appropriate and equitable solution to this problem.

**Dr. Conaway:** That is why I salute the efforts of a lot of hospital administrators, nurses, and physicians, who are writing letters to their senators and congressional repre-

sentatives urging them to reverse some of the very drastic cuts in reimbursement that were made in the federal program.

The one time that I had an opportunity to speak to President Clinton, the first thing that I said to him was: "Mr. President, you need to do something to reverse the Medicare cuts, because it really threatens our hospitals all over this country." He agreed with me and went on to talk about some of the things that he intended to do.

And so, you are right; the federal government is going to have to be a big player.

**NJM:** Since we are discussing payment for care, what do you think is the role of prescription costs in the overall picture?

**Dr. Conaway:** The pharmaceutical industry is right when it says that it has an important role to play in maintaining the quality of life and in the provision of health care. Most would agree that if you can provide a medication for a patient that would arrest a disease process or improve the quality of life without the need for hospitalization—whether that is through controlling arthritis, high cholesterol, or the ravages of heart

disease—that saves money for the entire system, and that makes sense to me. That is why it is so critical that those medicines, which are so important to health care and to the quality of life, be affordable by our senior citizen population.

I had many people write to me earlier this year when costs went up dramatically for prescription coverage under some of the Medicare HMO plans. The crossing guard I see every time I leave my home talks to me about the problems he has obtaining the medication he needs to control his cholesterol and the medication his wife needs to control her Parkinsonism. We need to do a better job of helping seniors afford these very expensive medicines. Some seniors are spending hundreds of dollars a month on medicines that maintain their health. We know what will happen if they do not take the medicine: they are going to have that heart attack, they are going to have that diabetes-related amputation, they are going to end up in the hospital. That is much more costly than it would have been if they were able to take the medications in the first place.

That is why I have argued for expansion of the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program here in New Jersey and fought the proposed cuts in that program that were brought up in the last session of the legislature. I have introduced legislation that would provide tax credits for people without pharmaceutical coverage who are purchasing their medications on

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their own. I am now looking for an even more dramatic expansion of pharmacy benefits under PAAD; it would allow people with higher incomes into the program, perhaps with higher copays or a higher deductible. There are so many people who are spending hundreds of dollars a month for medicines and who really cannot afford it. We must have a pharmaceutical assistance program that recognizes that even people who are not the poorest of the poor have great needs in this area. I am looking to expand the program to cover people who are making as much as \$30,000 per year. I think that is appropriate, and we must work to accomplish it.

**NJM:** Your insights are certainly right on the mark. There are a number of studies that indicate that the major inflationary driver in the cost of health care and health insurance, regardless of age, is in fact the cost of medication. Most employer plans, for example, have had significant rate increases that are directly pegged to prescription costs.

**Dr. Conaway:** As I understand it, it is not so much the cost of individual medications, but rather an inflation of utilization. As our population ages, there is an overall increase in the number of people who need the medications. Of course, some new medicines are costly. However, many of these are medications that are easy to take, improving patient compliance. Many of them have fewer side effects than previous medications, which generates substantial cost savings. And in many

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cases the new medicines are the only ones that a patient may be able to take.

**NJM:** Do you see price controls for pharmaceuticals on the legislative horizon?

**Dr. Conaway:** No, I do not. We do not apply price controls to other aspects of commerce. In my view, price controls would stifle innovation in the industry. There is some evidence that one of the reasons that this nation leads the world in innovation in pharmaceuticals is that we do not have price controls and we have an industry that is willing and able to invest large sums of money in research and development. We have to ask ourselves whether we want a healthy industry here in this country serving the world or whether we want to Europeanize our pharmaceutical industry, with the result that we would be less able to make the important breakthroughs in medication that we are enjoying today.

And so, I favor a system that will allow us to support people's ability to afford the medications that are available. This can be accomplished

through programs like the PAAD. Enhancing tax credits also would be helpful. The bottom line is that however we get there, we must have a thriving pharmaceutical industry and we must have a system in which patients are able to afford the medications they need to maintain their health.

**NJM:** There have been increased concerns expressed recently regarding the performance of and the standards for clinical research. Would you comment on this?

**Dr. Conaway:** The FDA needs the authority to protect patient safety. It needs the regulatory authority to evaluate potential conflicts and to make sure that the data being submitted to them is reliable. That is why the FDA is there.

**NJM:** Would you think there is a value to having the FDA perform random audits of clinical studies?

**Dr. Conaway:** Yes. It should be empowered to do anything that ensures patient safety. If random audits would help that process, then it should conduct them.

**NJM:** Dr. Conaway, we appreciate your frankness and your commitment to providing confidence in government, improving the health of our patients, and enhancing the environment in which we can provide health care. We have one last question: Will you consider running for the state senate any time soon?

**Dr. Conaway:** I might, under the appropriate circumstances.

**NJM:** We'll let you off with that answer for now, but we will ask again in the future. Thank you very much.

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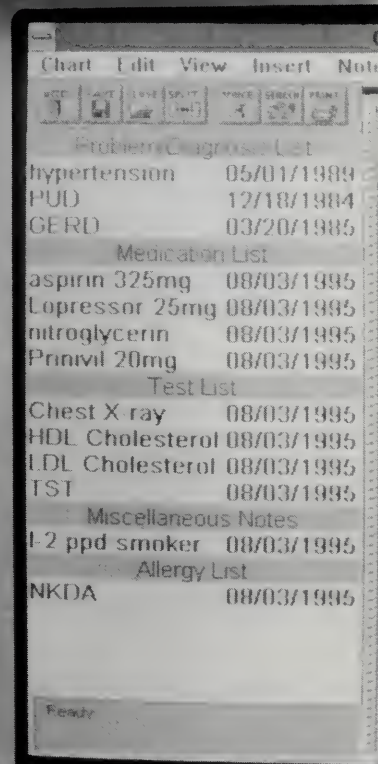
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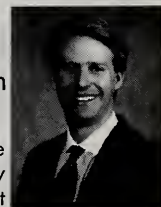
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# Address of Christine Grant, Commissioner, Department of Health and Senior Services

This is a terrific conference. I was here yesterday with Governor Whitman and had a chance to talk with many physicians. Much has happened in New Jersey in public health since I addressed you last year shortly after I had been appointed commissioner. We experienced Hurricane Floyd; managed the first identified emergence of the West Nile virus in the United States; struggled to balance competing interests of the public, physicians, hospitals, and Aetna when it sought to acquire Prudential's business; secured partial repayment for physicians and hospitals for services after the bankruptcies of two HMOs; managed the arrival and departure of 2,000 Kosovo refugees; and settled the tobacco lawsuits, resulting in \$7.5 billion in tobacco settlement monies for New Jersey. We also wrote and began to implement strategic plans for tobacco use control, adult and childhood immunization, and cancer prevention. All this was in addition to the regularly assigned work of a dedicated group of state employees and unpaid advisory groups.

During this past year my senior staff and I have had a wonderful working relationship with Dr. Irving Ratner. He has consistently combined a strong intellectual grasp of clinical and financial issues that concern physicians with the pragmatic constructive advocacy needed to negotiate regulations and shape coexistence of managed care.

But what has been most appreciated is best illustrated by a comment Irv made during one of the Hospital Advisory Commission meetings. It's rare to hear someone say "You know we should do this because it's best or the right thing for the patient." But I did hear that concern one day last year. When verbal shots were flying

about financial incentives, Irv stopped the group cold and said, "When are we going to talk about what's best for the patients? Isn't that what we're here for?" You are fortunate to have had Irv Ratner represent you.

I've already met Dr. Walter Kahn. I know we're going to have another good year with Dr. Kahn and MSNJ and the Academy of Medicine. We've also made special efforts to include representatives from the other societies including pediatrics, family practice, cardiology, surgery, rheumatology, neurologists, and infectious disease.

Today, I'll focus on four topics of particular interest to physicians. These deal with what we've accomplished and intend to accomplish:

- In hospital transitions and consumer and physician protections in managed care.
- In senior services to support better alignment of physician and hospital goals by helping seniors be discharged to the most appropriate setting for them, while helping you to manage hospital length of stay in the process.
- In tobacco control programs to dissuade children from starting to smoke and to help smokers quit.
- Through a new e-public health program in those fundamental activities of public health that rely so heavily on practicing physicians—identifying, reporting, and managing communicable diseases.

## Hospital Transitions

During the highly regulated hospital rate-setting era of the 1970s and 1980s, the state virtually guaranteed that insurers would pay the full financial elements of a well-



managed hospital, including full payment of charity care and bad debt.

Today's market-driven philosophy has modified the state's authority over hospital finance, although a half billion dollars of taxpayer dollars still subsidize hospital charity care every year.

When I spoke here last spring, the audience was furious at the financial situation of many hospitals.

At that time, I had just launched the Hospital Advisory Commission at the governor's direction to determine the factual basis for the significant decline in financial performance of New Jersey hospitals and to recommend actions for all involved parties—government, managed care and other payors, hospital boards and management, and physicians.

This year, I can report, we met our commitments and then some. The Hospital Advisory Commission identified four external and three internal factors as primary contributors to the instability in hospital finance. The external factors are:

- Reductions in federal Medicare payments, which, absent change in federal legislation, will persist for several more years.
- Accelerated penetration of managed care insurance in New Jersey, from 5% to 30% since the mid-1990s, and more stringent payment negotiations. These sometimes resulted in hospital managements agreeing to prices below their costs, to their detriment. Two serious HMO bankruptcies also contributed to hospital problems.
- Persistent increase in the dollar value of unreimbursed charity care. Although the same 12% to 15% of New Jersey's population has remained uninsured for 20 years, the situation is exacerbated by a higher influx of uninsured immigrants who are eligible for hospital charity care.
- Fundamental reduction in the demand for acute-care beds due to improved medicines and diagnostic pro-

cedures and growth of physicians' office-based services.

The Hospital Advisory Commission also identified internal factors:

- Reluctance of some hospital managements, boards of trustees, and physicians or local elected officials to make the tough decisions to change a hospital's mission, develop alliances, and reduce acute capacity while expanding diagnostic and ambulatory service.
- Persistent failure to align physician financial incentives with hospital financial incentives. This is generally believed to contribute to longer lengths of stay in New Jersey than elsewhere, even adjusting for age and severity.
- Suboptimal discharge planning and some hospital shopping by physicians with multiple admitting privileges.

The governor received the hospital advisory report in November. She took immediate action to address virtually every recommendation within the state's control. Her budget includes a package that can yield up to \$600 million in additional financial aid to hospitals and physicians in fiscal year 2001. It includes:

- Increased insurance—The proposed creation of FamilyCare, a new \$200 million affordable insurance program, will insure an additional 125,000 working adults of moderate income (to 200% of poverty level). This will be done by giving them subsidies to buy their employers' insurance or buy the state-sponsored counterpart to KidCare. KidCare has now enrolled more than 60,000 children. This insurance will add millions of dollars to physician and hospital revenues.
- Increased charity-care subsidies—Increasing the \$500 million in charity care by another \$30 million and modifying the formula will allow all hospitals to qualify for some amount after contributing a threshold amount of charity care.

- Repayment for bankrupt HMOs—The governor proposed and signed into law bill A-1890, the "New Jersey Insolvent Health Maintenance Organization Assistance Fund Act of 2000," providing up to \$100 million to physicians and hospitals left unpaid by the default of two HMOs.
- Creation of a hospital transition group and hospital asset transformation program in the Department of Health and Senior Services—We've assembled internal technical expertise in charity care, certificate of need, licensing, our senior services, and other program areas.

We've joined with colleagues in Medicaid, the Health Care Financing Administration, and attorney general's office to devise strategic and tactical action plans for hospitals in financial distress, as well as financially healthy hospitals wanting to accelerate significant consolidation or change mix of services during the year. I've met with more than a third of the hospitals' management, their board members, and physicians to discuss what changes they want. We are working on about 9 projects involving 12 of the state's 92 hospitals that are in the process of significant consolidation or mission change. There is no reason—I repeat, no reason—to think this is a financial crisis.

Virtually every one of these institutions is making prudent decisions, given the health care environment. We all recognize the symbolism that a hospital has in the community. This is why physicians have a responsibility to help the public and elected officials understand that health care has changed. You're driving change. While the press obsesses on the number of acute-care beds, the more significant change is the permanent one in the mix of services hospitals will provide, because you physicians are changing your practices.

**Recovery of Denied Federal Medicare Dollars.** The governor continues to advocate with the congressional delega-

tion and the state's hospital associations to recover up to \$400 million in denied Medicare payments from the federal Department of Health and Human Services. The first recovered dollars are beginning to flow into New Jersey.

**Regulations to Protect Emergency Services when Hospitals Consolidate.** Additional regulatory changes are under way, including a freestanding emergency-service provision to retain emergency care in communities in which a hospital no longer provides inpatient services. We insist on community involvement to ensure ambulatory services and transportation for patients and families. We are increasing support for federally qualified health centers, which provide much care to the state's uninsured.

## Managed Care and Consumer and Physician Rights

Much has occurred since we met last year, when I listened to your concerns about medical denials, slow pay, and closed formularies.

My authority as commissioner of health primarily addresses consumer and physician complaint resolution, adequacy of medical networks, and collegially with the Department of Banking and Insurance solvency reviews and prompt pay of claims.

Let me list the most significant developments.

**Health Care Quality Act Regulations Adopted.** The Health Care Quality Act regulations have been adopted. They provide for uniform standards for all HMOs and managed care organizations. We heard loudly and clearly from MSNJ's leadership about what bothers physicians. These regulations include numerous physician and patient protections. For example, the regulations:

- Use the prudent-layperson standards in the definition of emergency so payment isn't denied.
- Establish standards for provider agreements, including the right of the physician to communicate openly



with patients about diagnostic and treatment options without penalty.

- Provide for participating physicians to review and comment on existing protocols.

Furthermore, we have established a process that plans must follow in reviewing applications from physicians to participate in their networks. We ensured that regulations covering termination of physicians from a network must include a timely hearing process. The department will emphasize our presumption that a managed care organization will provide for notice and comment before seeking to terminate any physician for fraud.

We also require HMOs to publish the process for contracting with or terminating physicians. Contract standards require that methods of reimbursement include periodic accounting and right to appeal to ensure additional compensation consistent with the contract.

My last point on this issue is that regulations extending the generally "open formulary" provisions to HMOs have been proposed, and the department is currently reviewing public comments on these regulations.

**Prompt-Payment Enforcement Under Way.** DHSS manages consumer and physician complaints about managed care. In 1999-2000, our managed care staff investigated 4,000 complaints and inquiries from consumers, physicians, and hospitals. Almost half of all complaints involve payment problems.

I met directly with the senior executives of the biggest HMOs to discuss the need for all parties to improve performance and, with the banking and insurance department, issued the first fines in this area for more than \$400,000.

Having worked on this issue of prompt payment for a year, let me stress very clearly that we will continue to investigate all bona fide complaints, but physician groups must insist their billing vendors follow procedures. We have actively supported passage of the HINT legislation,

which requires 30-day payment of clean electronic claims and 40-day payment of clean paper claims.

Of the 221 appeals of coverage denials reviewed by the independent utilization review organization (IURO) from March 1997 to January 2000, 127 were resolved in favor of managed care companies and 94 in favor of consumers or physicians. Managed care companies agreed to follow the IURO recommendations in 208 cases and declined to accept the recommendations 13 times.

**Claims-Tracking Study.** We have a study under way with the Hospital Advisory Commission and hospital and managed care representatives to trace hospital bills through the system to spot where breakdowns in communication occur.

**Enforcement of Aetna Acquisition.** The approval of Aetna's acquisition of the Prudential line of business included 30 conditions, which will be enforced over the next five years. This was a difficult decision and I recognize an unpopular one with physicians, but the law is the law. Independent of each other, the attorney general, commissioner of banking and insurance, and I found no reason to deny the application, with conditions. These conditions include significant opportunities for MSNJ to discuss concerns directly with Aetna management. They include opportunities to engage experts to assess whether any anticompetitive activities occur. They include binding IURO decisions on appeals. Joint meetings have already occurred. I will insist on further meetings to ensure we obtain the service New Jerseyans deserve.

## Seniors: Long-Term Care Choices

Governor Whitman created the Department of Health and Senior Services almost four years ago to consolidate more than 55 health and social service programs affecting seniors.

The strategic goal is to create a continuum of community-based long-term care options for seniors

and their families so they can choose how to live with dignity and independence.

The benefits of these programs for physicians should be obvious. Not only does it provide you and your staff with resources for your stressed-out patients and families when they require day or alternate care, these programs will help you achieve appropriate lengths of stay for your patients through really effective discharge planning and reduced readmissions.

**Programs to Help Your Patients.** We've now introduced the New Jersey Easy Access Single Entry (EASE) program in 20 of 21 counties. NJ EASE is a consumer-friendly information system that allows seniors and their families to call one number anywhere in the state and receive information and services from the county in which they live. Help us publicize this number—(877) 222-3737—so your patients can obtain the list of services available and also obtain the help of a care manager.

We commissioned Rutgers' Center for State Health Policy to conduct a survey on the success of the Community Choice Counseling program. This is a one-on-one counseling, referral, and assistance program. Social workers and nurses go into nursing homes and hospitals to work with seniors who want and are able to move from the nursing home back to a residential setting. We've helped 950 seniors relocate to the community this year—and more than 1,500 since the program began in 1998.

The survey sampled 107 participating individuals and families. Of those, 93% said they liked their current situation better than the nursing home. In addition, 84% also said they could now do things that make their lives more enjoyable. Only 6% had to return to a nursing home.

## Tobacco Use Control

Last year I promised we'd quickly launch an effective antitobacco program, and we have, with the help of the New Jersey Breathes coalition and physician members, among others.

The strategic goal is simple and clear. We must prevent children from starting to smoke and help smokers quit.

We wrote the state's strategic antitobacco plan last summer with help from advocacy groups, including MSNJ and the NJ Breathes coalition. The plan's strategy is based on the national consensus of employing multiple best practices. They include:

- An increase in tobacco cost, already in place.
- Counteradvertising to the tobacco companies' advertising. The media campaign will begin in the fall of this year.
- Enforcement of age-of-sale laws. New Jersey law permits enforcement even though the Supreme Court has disallowed FDA enforcement.
- Peer-to-peer and other youth coping strategies. Twenty thousand students are already participating in almost 100 schools. A statewide youth corps is also planned.
- Community alliances to change community norms on smoking and further reduce environmental tobacco smoke. The New Jersey Breathes, Heureka, and the Group to Alleviate Smoking Pollution (GASP) organizations are focusing on pharmacies and restaurants.
- Smoking treatment programs for all who want to quit. We know that almost 60% of insurance already covers cessation, but it is not widely used, and training of health professionals is needed.

Governor Whitman has proposed \$30 million of this year's tobacco settlement be used for antitobacco campaign use. I'm very comfortable with that amount and intend to show the legislature we can make good use of every penny.

We have a baseline against which we can demonstrate progress. A few weeks ago, we released copies of the Youth Tobacco Survey, a fall 1999 middle and high school survey commissioned by the state's new School of Public Health at UMDNJ. The survey includes responses from



16,000 students in 164 middle and high schools throughout the state.

The findings provide a disturbing but not surprising baseline of tobacco use in New Jersey's children. You must and can help us change community norms.

Overall, 19% of NJ middle school students and 39% of high school students are current users of any tobacco products (including cigarettes, smokeless tobacco, cigars, and bidis). In addition, 10% of NJ middle school students and 28% of high school students report smoking cigarettes in the 30 days preceding this survey. A significant increase is noted between 7th and 8th grade, where cigarette use increased by 128%.

Among current smokers who purchased cigarettes in the past 30 days, 39% percent report they purchased their cigarettes at a convenience store and 26% percent purchased them at gas stations.

Among current established smokers, more than half (55%) express an interest in quitting and report a serious quit attempt in the past year (51% percent). Among current established smokers wanting to quit, 43% did not think they could.

The rate of current cigarette smoking by middle and high school students almost doubles when a student lives with someone who smokes. Current cigarette use is lowest (5%) among students who have no close friends who smoke and highest (66%) among students whose four closest friends all smoke.

These facts are startling. What can you as practicing physicians do? Given the competing demands on your time, we need you to figure out how you want information provided to you to allow you to help your patients quit smoking. What office-based materials do you need?

And we need you to use your leadership positions in your communities to ensure that the New Jersey tobacco age-of-sale laws are enforced. As I've said, more than one-third of the children buying cigarettes are doing so at convenience stores and gas stations. Almost half

already believe they can't quit. These are our children or their friends.

## E-Public Health

Given all the health issues we face, what I most worry about is that we will miss the early warnings of an outbreak of infectious disease and that people will die as a result. We had a close call with the emergence of the West Nile virus last summer.

New Jersey is the country's most diverse state. Tens of millions of people traverse the regional airports and harbors. Hundreds of millions drive through our highways. We are not able to identify and investigate disease outbreaks the way we optimally would want to. You know it. I know it. It's just a matter of time before a significant outbreak occurs and everyone will know it. We need to get back to basics and ensure timely case reporting by physicians, hospitals, local health officers, and laboratories.

**Epidemiologic Training and Deployment.** We need to strengthen our approach to adequately train and deploy personnel to analyze case reports, investigate and manage patterns of emerging disease, and improve workforce productivity.

**Communicate Electronically.** The Internet and increasingly cost-efficient electronic and telecommunications systems now offer the tools needed to better train, more easily report, and accurately and efficiently diagnose and communicate information to prevent the spread of disease.

The Public Health Protection and Communicable Disease Divisions have already begun to implement 24 county and large city local information and health-alert e-mail networks. We began to use these to send notices for Hurricane Floyd and the West Nile virus and just last week to transmit information to local health officers about meningococcal outbreaks among certain European

groups returning from Mecca. This is one of the most exciting developments in basic public health in years.

I am very pleased that Governor Whitman has recognized the importance of basic public health communicable disease infrastructure and the role of practicing physicians in it.

The governor is proposing \$6.9 million in the fiscal year 2001 budget to:

- Upgrade the electronic Local Information Network Communications System (LINCS) and health-alert systems connecting 24 county and local public health systems and a growing roster of hospitals and police and fire departments. These systems now have the ability to connect with nearly 1,000 health care professionals.
  - Implement a one-portal interactive Web-based communicable disease-reporting network for the benefit of state and local public health physicians, hospitals, and laboratories and train people to use it.
  - Increase local public health workforce productivity by training and strengthening integrated communication and long-distance learning systems.
  - Strengthen the capability of the state's laboratory to test for emerging diseases, such as West Nile virus or the remote but real threat of bioterrorism organisms.
  - Complete what would be the nation's first Web-enabled immunization registry to meet the needs of physicians and parents. I recognize that at the present time there is little incentive for physicians to report disease as required by law and regulation. You are asked to report diseases, some by phone to different offices, some in writing to other offices, and frankly, rarely with any feedback. The staff of Public Health Protection wants to change this and create a one-portal truly interactive system for you and with you.
- E-public health promises a smarter way to conduct our public health work. It already has gained and will leverage additional federal funding for important public health initiatives for which we have been unable to compete.

In closing, as the state's commissioner of health and senior services, I'm asking for your help:

- Ask your office manager to obtain written confirmation from your claims submission vendor that it understands and complies with the claims submission requirements of each of the major NJ HMOs—Horizon, Aetna, and Oxford United. Question what the vendor is doing to improve its clean bill submission rates and reduce your rejection rates and speed payments.
- Write a letter to your local paper or talk to the convenience store manager where you buy coffee and your gas station manager expressing concern that 39% of New Jersey high school students report using tobacco regularly, that they're twice as likely to smoke if their parents or friends smoke, and that one-third of the smokers who buy their own cigarettes still can buy them illegally from convenience stores or gas stations. Order your patients who smoke to quit, and tell them the impact it has on their children.
- Help your older patients and their baby-boomer children to have access in your office to the information they need to obtain home care, respite care, adult day care, or good nursing home or assisted-living care.
- Bookmark the Department of Health and Senior Services Web site—[www.state.nj.us/health](http://www.state.nj.us/health). And finally, give me some advice as to how we can make communicable disease reporting more user-friendly.

There is much in place in New Jersey for the most productive partnership between physicians and the public health and the senior services programs for many years. The money's here; the technology's here; and the knowledge of what to do is here.

It's the follow-through that we have to work on together.

If we do, we can truly make New Jersey a better place to live, work, raise our families, and retire with independence and dignity.



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# Physician Practice Support in Transition

Richard L. Reece, MD

**I**ntegrated delivery systems (IDSs) are disintegrating, and hospital-physician relationships are dissolving. For hospitals, the old health care economy's cornerstone, this chaotic period means financial crises, dropping margins, and downsizing. Specifically:

- Academic medical centers are under siege, going bankrupt, and begging for help.<sup>1-3</sup>
- Community hospitals are pleading for state tax aid to offset Medicaid and Medicare losses.<sup>4,5</sup>
- Hospital-based IDSs are losing \$83,000 to \$111,000 per acquired physician per year.<sup>6,7</sup>
- Hospitals' operating margins are falling—from 6.3% in 1997 to 2.7% in 1999.<sup>8</sup>
- Major hospital systems are abandoning physician hospital organization (PHO)-based health maintenance organizations (HMOs) and selling them to for-profit health plans.<sup>9</sup>

## Structural Integration, Cultural Disintegration

Here's futurist Jeff Goldsmith's take on disintegrating hospital-physician relationships:

Only a handful of IDSs are generating decent economic returns, and many have more than equaled operating profits from hospitals with health plan losses and losses from acquired physician practices . . . *But more significantly, as health systems integrated structurally, they disintegrated culturally* [italics the author's].<sup>10</sup>

## Hospital Control and the Physician Culture

The controlling mentality of some hospital executives creates much of the cultural chasm problems. This control mindset is understandable. After all, administrators must account for their actions to hospital boards, made up of businesspeople. However, hospital executives still do not understand the essence of the physician culture.

Physicians pride themselves on being independent professionals, able to function alone or in small groups; that is why most doctors still practice in groups of five or less. Physicians want practical information to help them succeed and maintain their independence and income, not comprehensive computer systems or organizational management systems that slow them

down and generate information to imprison them in restrictive guidelines.

Physicians are smart enough to know that hospitals, HMOs, management companies, and large group practices have had their runs at owning, organizing, and employing physicians, and that all, for the most part, have failed. Furthermore, physicians understand the "physician culture," its strengths and its weaknesses and its underlying cohesion. They respond to comparative data that they control, share, understand, and help create and that advances and improves patients' outcomes: that's why the handheld palm-sized computers that permit doctors to enter their own accurate diagnostic codes are so powerful. Tools like this will pull physicians across the technological chasm now separating the old practice of medicine from the new. Physicians prefer not to be owned, and the Internet's promise is that it will provide them with bottom-up information to empower them, make them more efficient, and help them remain in their own practice.



## The Shift Away from Hospitals

In the past, the hospital was the center of the health care universe, and for good reasons too. After all, US physicians receive most of their training within hospitals, chiefly in academic medical centers or in other teaching hospitals. In addition, hospitals and health care are often the biggest employer in a community. In the nation as a whole, hospitals consume almost 40% of the health care dollar, twice the 20% flowing to physicians.

But during the past 10 years, the health care delivery-organizing center has shifted away from hospitals. This is partly because of managed care, which profits by keeping people out of hospitals. It is partly because of the government, which is creating Medicare HMOs, cutting hospital reimbursement, and fining hospitals as centers for fraud and abuse. It is partly because of new technologies, which make it possible and profitable to perform 90% of procedures outside of hospitals.

### No Compelling Logic for Organizing System Around Hospitals

James C. Robinson, PhD, associate professor of health at the University of California-Berkeley, and Lawrence P. Casalino, MD, PhD, a clinical assistant professor of family medicine at Stanford and a community-based family practitioner, expressed clearly what was going on in the California marketplace in 1996:

The nature of the organizational relations between medical groups and hospitals is one of the central questions for the future of the health care delivery system. Managed care aims to shift the focus of medicine away from the acute inpatient facility to the outpatient office, the subacute facility, and patient's home. *Organizing a delivery system around the hospital has a less compelling logic with each passing year [italics the author's].* There exist few scope economies between hospitals and physician services that cannot be achieved through contract; little advantage of integrated over contractual partnerships in bearing captivation risk; little if any gain in shifting the transaction costs of negotiating, monitoring, and enforcing agreements from the expert market to the internal pseudomarket; and only a modest sharing of core competencies between running a hospital and running a network of primary care clinics.<sup>11</sup>

### Hospitals Continue to be Essential

Hospitals are not going to fade away. The population is aging too dramatically. Today, Medicare patients occupy 50% of hospital beds, and that percentage will increase in the years ahead.<sup>12</sup> In 2000, 12% of Americans are older than 65. By 2030, 20% of Americans will be older than 65. Sixty-five-year-olds consume five times the health resources as twenty-five-year-olds.

As the uninsured population, now 45 million, grows, the need for

hospital emergency rooms grows too. Hospital emergency rooms still constitute this population's principal route to care.

Finally, critical illnesses and new technologies demand hospitalization. It is impossible to imagine coronary bypass surgeries, transplants, most intraabdominal or intrathoracic procedures, or most radical cancer surgery being performed in nonhospital settings.

### Being Essential Does Not Constitute Control

Hospitals have sought to maintain control as the center of health care delivery. The results have not always been happy. Take the example of hospital-backed HMOs. By and large, these HMOs have failed, in part as a result of hospitals' inexperience in marketing HMOs and in underestimating the capital demands of setting up and maintaining HMOs, and in part because of the inherent conflict between hospitals, who need more patients, and physicians, who lose money by hospitalizing patients and dealing with HMOs.

### So Where is the Center?

So if hospitals have proved ineffective as the center of health care delivery, who should occupy the center? Certainly not physicians—there is simply no cohesive organization large enough to do the job. The American Medical Association has only one-third of practicing physicians as members, and its for-profit Web site, medem.com, is still in a

preliminary phase. And although there is much talk about a consumer-driven health system, consumers are still too disorganized to mount a takeover of the system.

Finally, the combined impact of an aging population, accelerating financial demands, and rapidly developing technology is simply too much for employers or the government to handle.

The solution, believe it or not, may be the Internet companies that have the potential to rid the health care system of all those intermediaries and all that paperwork that stands between patients and physicians. There are other approaches as well.

In the first approach, hospitals introduce comprehensive systems to their physician groups. Some large hospital systems spend as much as \$35,000 per physician per year to install and keep their integrated Internet, intranet, and comprehensive office information system up and running.

Physicians, however, spend only about 2% of their gross revenues on information technologies, compared with 10% invested by other industries, such as insurance, banking, and airlines. Physicians have been reluctant to invest because comprehensive systems have not proved on a broad scale to increase physician incomes or productivity.

Recently, a less expensive alternative to internal comprehensive systems has emerged.

This new service goes by the name of application service provider. It outsources information and business functions over the Internet. Dave McComb, vice president of OrganicNet, Inc., an application service provider in San Francisco, and James Snyder, MD, vice chairman of the department of medicine, University of Nevada School of Medicine, Las Vegas, say that application service providers can cut software costs of physician practices. Snyder defines an application service provider as an organization that "hosts, deploys, and leases software applications over the Internet from a centralized network facility that it manages." McComb adds, "Some information technology industry analysts estimate that the total cost of hosted applications can be 25% to 30% less than licensing and managing applications internally."

The third approach, called "chunking," offers physicians practical solutions one at a time for complex office problems. If physicians are given solutions at the right price—which is low cost or free over the Internet—they will become true believers.

Chunking, a term coined by journalist Kevin Kelly, is a concept that describes how complex systems are constructed from the bottom up with building blocks that have been proved to work on their own.<sup>13</sup> Physician practices should start small, experiment to see what works, then link the pieces together in a

system that fits their practice style, which is not the top-down style of a large corporation.

## An Example

For small or solo practices, chunking is a natural way to go. For example, Dr. David Bright, a solo family practitioner in Stuart FL, and his physician assistant (PA) have put together an integrated system that has been live for two years. They use speech recognition software linked to clinical, referral, dictation, patient education, and prescription templates.

Using this system, Bright and his PA see 50 patients a day in six examining rooms. At the end of the day, they've completed all their dictation, in the process saving \$15,000 in transcription costs a year. They work and talk their way through the day by speaking naturally to voice recognition software and calling up the appropriate templates to dictate, prescribe, and refer. The reliability of their speech recognition is about 98%, "good enough for our purposes," says Bright.

Chunking has allowed Bright to build a complex integrated system out of simple systems that work well alone and are capable of operating independently. In addition, they are paying for the system as they go. They test each software component for clinical usefulness, calculate its return on investment, and then add it to the integrated system. Bright says his system has paid for itself along the way.



In addition, chunking may spare some harassed physicians the difficult, time-consuming, and energy-draining experience of listening to hours of presentations by information company representatives on how to reorganize their practices to fit the vendor's system. Bright says he has listened to more than one such presentation and usually returns to his office seething with frustration that they did not understand his problems.

### Chunking Does Not Require Large Up-front Expenditures

Practical solutions to complex clinical and business problems do not require \$30,000 or more of up-front investment by each doctor. A solo practitioner who wants to dictate reports over speech recognition software, for instance, needs only a personal computer and printer (roughly \$1,500) professional speech recognition software (around \$200), and a good soundboard for the computer (about \$70).

Furthermore, many practical solutions are free over the Internet (although the practice must pay for Internet access itself); a few require purchase of CD-ROMs. A few of these current services are shown in Figure 1, but there are hundreds, if not thousands, on the Web.

### Brave New World

The health care world is making a turbulent transition from care organized around hospitals to care organized around physicians connected over the Internet to other health care professionals. The biggest obstacles to making this transition

are hospitals' understandable reluctance to let go at the top and physicians' lack of comfort with the Internet. The services currently being offered—health news, customized medical information for specialists, ordering books, supplies, and lab results—are of marginal interest to physicians. Other services, such as scheduling appointments, checking lab results, and checking insurance eligibility, will draw more interest. But those services that are likely to persuade physicians to use the Internet are free or inexpensive solutions to common office problems—how the practice compares with others, how to code to generate decent revenues without inviting HCFA audits, how to create and use Web sites to market the practice, how to use e-mail and the Internet to reduce the use of the phone, how to coordinate the work and information flow in the office, how to customize patient care and education information, and how to increase productivity without sacrificing—indeed the goal is to maximize—time with patients.

Richard L. Reece is editor-in-chief, Physician Practice Options, Old Saybrook CT. An earlier version of this article appeared in the May 2000 Connecticut Medicine.

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| Complex Problem                                                                                                                                    | Practical Solution                                                                                                                                                                           | Approximate Cost                                                                                                                                                                                                                                    | Practice Benefit                                                                                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Alerting and educating your patients to health dangers of obesity, inactivity, hypertension, and bad blood lipids.                                 | HealthStatusIQ, available as CD-ROM.                                                                                                                                                         | In development, should be available by July 2000.                                                                                                                                                                                                   | Helps establish your practice as center for health and wellness education, attracts new and loyal clientele, gives patients tool to track their health.                                                |
| Seeking online CME credits.                                                                                                                        | CME-online.com, developed by Milliman & Robertson. You may wish to search "CME" credits on the Net, or to visit such sites as Medsite.com or Medscape.com.                                   | \$69 per CME credit.                                                                                                                                                                                                                                | First course is "Positioning your practice for 2005," an informative interactive seminar to help you prepare for the future practice business climate.                                                 |
| How to guide patients to well-managed personal care once they leave your office.                                                                   | <i>Healthcare Companion</i> , available as booklet or CD-ROM, patient guidelines developed by Milliman & Robertson to ensure better care outside the office setting.                         | \$35.                                                                                                                                                                                                                                               | Reduces calls to office, helps market practice and retain loyal patients by addressing issues of when to call doctor, when to go to ER, model Rx including OTC drugs, when to go to specialist.        |
| Depression may masquerade as impaired work performance, absenteeism, disability, and health care overuse.                                          | The HANDS Screening Tool, a 13-point, single-page questionnaire developed by Harvard Department of Psychiatry.                                                                               | Free, may obtain by calling (781) 239-0071 in Wellesley MA or by directing patients to <a href="http://depression-screening.org">http://depression-screening.org</a> .                                                                              | Spotting depression quickly can save your practice time and money and can result in early treatment. This is primarily a clinical productivity tool to serve as triage.                                |
| If you're a busy specialist practicing in multiple locations, you may have difficulty consistently capturing the right codes at the point of care. | Mdeverywhere.com has developed a code-capturing device. Codes are entered by the physician on a Palm handheld computer and then downloaded at the physician's convenience over the Internet. | Costs are about \$2 per transaction entry. More details can be obtained through <a href="http://mdoptions.com">mdoptions.com</a> linkage or through the <a href="http://mdeverywhere.com">mdeverywhere.com</a> Web site.                            | The mdeverywhere.com system has increased revenues and cut transaction costs. Free Palm Pilot comes through using the service.                                                                         |
| Writing legible prescriptions and transmitting those prescriptions to pharmacists is a complex process fraught with errors.                        | AllScripts.com and ephysician.com are electronic prescription services.                                                                                                                      | Consult Web sites for cost. Ephysician uses a Palm handheld computer to prescribe. AllScripts uses a portable small computer and TouchScript, a personal prescriber, to send prescriptions to local pharmacies, mail order, or Internet drug firms. | These systems offer medical information on drugs, drug interactions, and safety. They speed up prescribing and eliminate safety problems of handwriting illegibility and minimizing drug interactions. |
| Identifying the right CPT-4 code to ensure proper compensation and HCFA compliance.                                                                | Paladin, an expert E&M coding and HCFA-compliance system.                                                                                                                                    | CD-ROM, \$399, requires about 30 to 60 seconds per patient to arrive at right code.                                                                                                                                                                 | The typical physician undercodes an average of \$20,000 a year to avoid HFCA prosecution.                                                                                                              |
| Assessing financial status of practice compared with similar practices of similar specialists.                                                     | VPmanager.com.                                                                                                                                                                               | A free Internet service. If follow-up consulting is requested, it will be provided on a fee basis.                                                                                                                                                  | This service lets a practice know how it stands financially and identifies staffing, overhead, and productivity variances compared with other practices.                                               |

Figure 1. Examples of free or inexpensive Internet solutions to common complex problems encountered in clinical practices. The author sits on the board of VPmanager.com but has no direct relationships with other companies mentioned.



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# Research and Practice: Ethics at a Muddled Middle

*T. Patrick Hill*

**T**he blurred line between medical research and practice creates ethical dilemmas on both sides of that line. A classic example of this blurring and the problems it creates is the determination of cord blood pH, part of "standard care" for infants in many teaching hospitals.<sup>1</sup> A low pH reading may result in immediate treatment of the infant for acidosis, although it is not clear if such treatment improves, worsens, or has no effect on outcomes. How, then, should we classify the use of this procedure when its benefit to patients is uncertain? Is it clinical practice, therapeutic research, or nontherapeutic research?

Because it can put patients at risk, the blurred distinction between research and practice remains an ethical concern in the delivery of medical treatment. For example, in a typical integrated hospital system there is evidence that research on human subjects often occurs in the course of clinical practice, but clinicians or researchers do not always consider it as such. As a consequence, the ethical protections afforded to research subjects (e.g., informed consent) are absent. The relevant literature also reveals many examples of research carried out

under the appearance of clinical practice, including nonvalidated practices and interventions, off-label use of medications, and retrospective research on novel interventions.

The blurred distinction between research and practice occurs across the continuum of care in sites as diverse as pediatrics, oncology, surgery, and psychiatry. In its 1994 report "Identifying Health Technologies that Work," the Office of Technology Assessment (OTA) observed that "data collected in the course of routine patient care and by health insurers is increasingly being used in efforts to change clinical practice. Collated provider data is used to promote discussion about correct practice among physicians' colleagues to compare the outcomes of care across physicians and institutions as a means of targeting quality improvement efforts."<sup>2</sup>

The OTA noted three possible reasons for the blurring of the distinction between clinical practice and research:

- Much of what medical care considers customary practice was established before rigorous testing for efficacy became common.
- A great number of newly introduced technologies, even today,

are not required to show rigorous evidence of efficacy before they are adopted. Promising new procedures are thus often widely publicized and adopted by physicians and patients without undergoing any formal evaluation. The estimate in the OTA report that only between 10% and 20% of procedures have ever been formally evaluated for efficacy and safety remains true.<sup>3</sup>

- Drugs tested and approved for use in one type of cancer (for example) are frequently used to treat other cancers as well. Neither the providers nor the patients can be certain that a treatment used for a new population or in a new setting will actually have the same risks and benefits as those shown in the initial efficacy studies.<sup>4</sup>

These observations point to a gray area in modern medicine where treatments that have not been demonstrated to be effective and safe by means of prospective research protocols are used on the strength of retrospective research of their actual outcomes or are applied randomly on the basis of positive outcomes in another setting.

The serious ethical implications and the enduring nature of the



problems created by the blurring of the difference between clinical research and practice have been widely recognized. Whether they have been properly addressed remains questionable. For example, in 1975, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (hereafter the Commission) clearly acknowledged this matter in its discussion of innovative therapies: "Uncertainties may be introduced by the application of novel procedures as, for example, when deviations from common practice in drug administration or in surgical, medical, or behavioral therapies are tried in the course of rendering treatment."<sup>5</sup> The Commission's concern was clinicians' use of innovative therapies in an unsupervised manner, as part of practice. But its conclusion was that, while these applications may be designated as innovative therapies, they do not constitute research until they are placed within a formal research protocol. Any summary case review, however, indicates that research is occurring outside formal research protocols. One example must suffice here. In 1975, an effective regimen of chemotherapy, consisting of four drugs—cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP)—was developed for treating intermediate-grade, non-Hodgkins lymphoma. This first-generation regimen produced complete remission in 44% to 45% of patients and cure in approximately 30% to 35%.<sup>6</sup> During the following 15 years, several large lymphoma

referral centers experimented with variations of the original regimen, such as changing or adding drugs, changing the sequence of their administration, or altering the dosage. With what appeared to be better results, the new regimens were reported and published. Compared with the original regimen, a second generation of drugs (methotrexate, leucovorin calcium, bleomycin, doxorubicin, cyclophosphamide, vincristine, dexamethasone [m-BACOD]), followed by a third generation of drugs (prednisone, doxorubicin, cyclophosphamide,

etoposide, cytarabine, bleomycin, vincristine, methotrexate, leucovorin calcium [Pro-MACE-CytaBOM] and methotrexate, doxorubicin, cyclophosphamide, vincristine, bleomycin, prednisone, leucovorin calcium, trimethoprim/sulfamethoxazole, ketoconazole [MACOP-B]) appeared to achieve remission and cure rates between 55% and 65%. But not until a randomized clinical trial of the most promising of these was undertaken did it become clear that the regimens were absolutely equivalent.<sup>7</sup> Moreover, the randomized trial demonstrated that none was better than the original CHOP regimen. Significantly, however, it did demonstrate that some of the more complicated second- and third-generation regimens were more difficult to administer, more toxic, and more expensive than the original.

In the 1979 Belmont report, the Commission also noted the gray area between research and practice: "The distinction between research and practice is blurred partly because both often occur together (as in research designated to evaluate a therapy) and partly because notable departures from standard practice are often called 'experimental' when the terms *experimental* and *research* are not carefully defined."<sup>8</sup> In the report, the Commission seems to conclude that since the terms *research* and *practice* can be theoretically differentiated, they can be similarly differentiated in the clinical setting. But where does this conclusion leave the report's own observation that the distinction between research and

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THE ETHICAL  
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(E.G., INFORMED  
CONSENT) ARE NOT  
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IN PRACTICE.

practice is blurred precisely because they often occur together? Clearly there is a need to recognize the practical implications of the fact that practice is always open to being research and, as a review of the relevant literature demonstrates, practice has actually been and continues to be research in the clinical setting.

The terms we use to understand the relationship between research and practice contribute to this ambiguity. According to Tyson, the Commission attempted to address the matter by distinguishing among three areas of activity. The first was research, which it defined as "the systematic collection of data or observations in accordance with a designed protocol." The second was therapeutic research, which "refers to research designed to improve the health or condition of the research subject by prophylactic, diagnostic, or treatment methods that depart from standard medical practice." The third area defined was nontherapeutic research and "refers to research not designed to improve the health of the research subject by prophylactic, diagnostic, or treatment methods."<sup>9</sup>

In reviewing the Commission's definition, some critics considered the concept of therapeutic research to be a contradiction in terms. Since we conduct research to increase knowledge and not to benefit a particular patient, these critics felt it was not possible to think of research as possessing a therapeutic function. In contrast, others suggested that research could be considered therapeutic when, for example, the clinical

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evaluates interventions that have been designed to benefit individual patients. In this case, a specific research project may contain both therapeutic and nontherapeutic components.<sup>10</sup> If so, then therapy/practice can have a research function despite the Commission's contention that innovative therapy does not constitute research unless formally structured as such. The relevant literature clearly shows that innovative therapies are used for research outside research protocols.

While a neat distinction between research and practice may seem desirable, clinical experience confounds that effort. This is evident in the attempts to draw this kind of distinction by considering clinical practice. There are, Levine argues, three possible ways to do this. One is to consider the practice of medicine as a "class of activities designed solely to enhance the well-being of an individual patient or client," by means of diagnosis, preventive

treatment, or therapy.<sup>11</sup> Another way is to consider medicine as using "nonvalidated practices." Practices can be designated as nonvalidated for at least two reasons. One, they are new, meaning they have not been tested sufficiently to have adequate assurance of their safety. Two, while being used in clinical practice, they prompt legitimate questions related to safety and efficacy. It could be that practices were never adequately validated to begin with, as happened in the case of ligation of the internal mammary artery for the treatment of coronary artery disease. Or it could be that questions have arisen over previously unknown toxicity, as in the instance of the treatment of renal failure with certain sulfa drugs. Such discoveries rely on the research elements of clinical practice, especially retrospective review and consequently the ethical norms and procedures designed specifically for research might be applicable here also.<sup>12</sup>

The third way to consider medical practice is to see it as "practice for the benefit of others."<sup>13</sup> Organ transplantation, where the benefit goes to the recipient rather than the donor, is a good example. However, some would argue that since it is not directed to developing or contributing to generalizable knowledge, "practice for the benefit of others" is not research.<sup>14</sup> But why this practice cannot be considered research is puzzling, since Levine acknowledges that it has at least one thing in common with research, namely the burdens assumed by donors in the interests of the recipients. This



acknowledgment suggests how, in the clinical setting, practice can become research. In other words, the more we attempt to draw absolute lines of distinction between research and practice, the more their functional interdependence becomes clear. Since it is possible that practice, particularly nonvalidated or experimental practice, becomes research, the ethical protections afforded patients as a matter of course in formal research protocols need to be available to patients in those clinical situations where the roles of physician and researcher have become functionally interchangeable.

Efforts to achieve conceptual clarity over the difference between research and practice and to set clear boundaries between them are ultimately unsuccessful. Because of the limitations of medical knowledge at any one time, the experimental use of unproved treatments will always be common and unavoidable. Under these circumstances, "neither patient welfare nor autonomy are well served by the double standard requiring institutional review and written informed consent for experimentation in research but not for experimentation in clinical practice."<sup>15</sup> For ethical reasons, there is serious—indeed urgent—need for practical methods to protect the interests of patients whenever experimentation occurs in clinical practice.

T. Patrick Hill was born in Ireland and educated in England at Cambridge University and in the United States at the University of California-Los Angeles. He is now completing

doctoral work in medical ethics, science, and technology at the University of Chicago. A long-standing member of MSNJ's Committee on Biomedical Ethics, he was a research scholar at the Park Ridge Center for the Study of Health, Faith, and Ethics in Chicago from 1995 to 1999. He has been a consultant to numerous institutions, most recently serving as ethicist to The New Jersey Working Group to Improve Outcomes in Cancer Patients that reached, for the first time in the United States, a voluntary agreement with the major health insurance companies to cover the routine costs of all phases of clinical trials in cancer. Currently a part-time staff member at New Jersey Health Decisions, he is project manager for the Robert Wood Johnson-funded New Jersey Comfort Care Coalition. His work has been published widely, including his influential paper, "Treating the Dying Patient: The Challenge of Medical Education," (Archives of Internal Medicine) and his book, *A Good Death: Taking More Control at the End of Your Life* (Addison-Wesley).

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# Update on Physician Education and Training Requirements

*Bernard Robins, MD*

**T**he New Jersey Board of Medical Examiners (NJBME) has entered into a process of initiating certain programs that will ensure that New Jersey physician license requirements are appropriate for supporting physicians' ability to provide for the health care needs of their patients. Because of the increasing complexity of medical practice, including the daunting amount of knowledge needed and the convolutions of delivery systems, it has become increasingly difficult for physicians to achieve and maintain competence. In addition, the measurement and judging of competence is also anything but a simple matter.

NJBME has moved to introduce three initiatives to meet this goal. The first is an attempt to respond to the quality-of-care issues that arise when a physician has demonstrated some diminution of skills because of any number of legitimate reasons, including an extended absence from practicing medicine. NJBME has taken the initial steps in bringing together the medical education leadership in the state, including MSNJ and the Academy of Medicine, to assist in the development of a nondisciplinary assessment and retraining program.

A second reform under consideration is extending the requirements for plenary licensure to more than one postgraduate year of training. It is clear that specialty boards, managed care organizations, and hospitals all require more extended training in their credentialing of privileges. It is equally clear that the one postgraduate year now required for US graduates is inadequate training in the modern world of medicine. Ideally, plenary licensure should require at least attaining the standards of education that would be equivalent to those needed as prerequisites for specialty-board certification. The third area of concern to NJBME is the problem of ensuring the continued competence of licensees. Although continuing medical education (CME) is a requirement for membership in many professional organizations and hospitals, it is not a requirement for renewal of licensure in the state of New Jersey. More than 30 other states do have this requirement. It seems a logical step, therefore, to extend mandatory CME to all New Jersey physicians.

NJBME has engaged its regulated community in extensive dialogue, seeking input as how to best carry out all three ini-

tiatives, and held an informal conference in January 2000, which was productive and useful. In the area of mandatory CME, there seems to be a consensus that this requirement would be appropriate and well accepted.

Specifically, through a statutory change in the legislature, all licensed New Jersey physicians and podiatrists would be required to earn 100 hours of Category 1 or Category 2 CME credits as approved by such accrediting organizations as MSNJ, the AMA, the Academy of Medicine, the Osteopathic Association, or the Podiatric Association, in each biennial renewal cycle for licensure. Such a statutory change would then be the basis for the development of an NJBME regulation that would address more specific educational needs as identified by NJBME and the licensee community. Mandatory specifics, which would vary according to perceived need, might include pain management, medical ethics, and family violence, among others.

NJBME also feels that new licensees would benefit from a required number of hours during the first biennial cycle of licensure in such subject areas as the legal basis of medical practice, cultural competence, communications skills, and risk prevention. Appropriately, waivers would be given to those licensees who had just completed their training programs when this requirement is instituted.

Although subject to revision and refinement as this new requirement is developed, the tentative thinking is that the reporting of CMEs would be by affirmation on the biennial license renewal application. Compliance would be monitored by random audit of a sample of the renewal applications. Those physicians not meeting the statutory requirements for CME would be subject to the disciplinary process of NJBME.

Instituting these changes would allow NJBME to better assure the citizens of New Jersey that their physicians are well trained and keep up their studies to continue to be competent in executing their difficult professional duties in the new millennium.

*Bernard Robins is a member of and immediate past president of the New Jersey Board of Medical Examiners.*





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# Advanced Practice Nursing: A Boon to Physicians

Miriam Cohen, MS, RN, CS

Nurses who function in an expanded role are referred to as advanced practice nurses (APNs). There are two categories of advanced practice nurses—clinical nurse specialists (CNSs) and nurse practitioners (NPs). APNs are registered nurses, licensed and certified by the Board of Nursing (BoN) in their specialty area. The BoN requires all applicants to submit proof of specialty certification by a national accrediting body such as the American Nurses Association Credentialing Center. Applicants also are required to hold a master's degree in nursing and complete a three-credit graduate-level pharmacology course. The regulations further stipulate that all APNs complete 30 hours of continuing education every two years. The APN has both inpatient and outpatient authority to practice and prescribe. Both NPs and CNSs enjoy the same privileges, but the term NP is most familiar to physicians. The APNs working in physicians' offices are mostly NPs; hospitals and community/public health settings employ CNSs and NPs.

Recent legislation has expanded the prescriptive authority of APNs to include controlled dangerous substances (CDSs) (NJSA 45:11-49). As of February 2000, APNs in New Jersey were eligible to apply for Drug Enforcement Administration (DEA) registration. The conditions under which an APN may prescribe a CDS are limited to the following:

- Continuing or reissuing an order or prescription that was originally prescribed by the collaborating physician (prescription must state reissue).
- Adjusting the dosage of the medication after consultation with the collaborating physician or physician's designee (prescription must state dosage change).
- As part of the treatment plan for a patient with a terminal illness/an end-of-life situation (prescription must state "NJSA 45:11-49c(1)(b)").

A physician need not cosign prescription orders and charts; however, the full name, title, address, telephone, and license number of the collaborating physician must appear on the prescription. The

prescriptive authority for APNs requires jointly written protocols signed by the APN and the collaborating physician, which must be reviewed, updated, and signed annually by both parties. In an outpatient setting, a New Jersey prescription blank must also be used.

The Balanced Budget Act of 1997 enhanced Medicare coverage of NP services. Since 1998, Medicare part B services may cover NP services at 85% of the rate paid to physicians. Health Care Financing Administration (HCFA) regulations allow NPs to bill regardless of setting or location of service. Medicare may also cover services and supplies that are furnished incident to the NP's services. The term *incident to* is a reimbursement mechanism used in outpatient settings. Billing for such services is at 100% of the fee-schedule amount. When this billing method is used, Medicare requires the NP to be an employee of the physician and the physician to be present when the NP is seeing the patient. The physician must have initiated treatment and see the patient periodically. Some health



care policy experts who follow reimbursement trends believe that HCFA is moving away from incident billing. The choice of using direct billing or incident-to billing rests with the physician.

The value of NPs to the practice, however, can be viewed in relationship to their status as independent practitioners. Since they are licensed as independent practitioners, they do not require physician supervision. Therefore, liability for practice resides with the NP, not the physician. The NP may be employed as an independent contractor, which means that an agreement for services may be executed without the associated overhead. It might be reasonable for a group of physicians to independently contract with a single NP or group of NPs to provide particular services to patients in that practice.

The law allows NPs to practice without the physician on site. Some insurance companies, however, refuse reimbursement when the physician is not present during the patient visit. The New Jersey State Nurses Association (NJSNA) has been actively working with insurance companies to eliminate this restriction on reimbursement, and the prospects that the restriction will be lifted are good. Thus, physicians will be able to have NPs see patients in their offices while physicians are engaged in other professional activities.

A physician commented recently that the NP on his staff functions at a level commensurate with that of a junior fellow. The NP can perform initial histories and physicals as well as follow-up visits and assess patient adherence to and experiences with treatment regimens. Since a physician cosignature on charts or prescriptions is not required, patients can be examined without interruption. The number of patients that can be accommodated during office hours is increased at a lower cost than might otherwise be incurred. Within the guidelines of the newly expanded prescriptive privileges, the NP can assist the physician in managing patients with terminal conditions or with chronic pain.

One of the more novel ways of using an NP's services is in the provision of visits to homebound patients. Although physicians value home visits, they are time consuming and reimbursement frequently does not equal the time and effort required. Physicians already juggling their schedule of office, hospital,

and paperwork obligations are hard-pressed to add even more work-related responsibilities. On home visits to these patients, NPs can provide patients with physical exams and medications and adjust prescribed therapies as necessary. The NP can provide the physician with valuable information about the patient, and the patient receives more comprehensive care. As an added bonus, the visit is reimbursable at 85% of the Medicare physician-fee schedule. NPs can also visit newly admitted hospital patients, allowing physicians to optimize their time management while knowing that their patients have received attention.

Anecdotally, physicians report that adding NPs to their staff has enhanced their practice and their revenues because NPs like to refer patients to practices where their colleagues are employed. Increasing the volume of the practice, decreasing physician stress, and providing a high quality of patient care is a winning situation. The exploration of ways to provide high-quality care and maximize reimbursement through the use of APNs has just begun. As Andrea Aughenbaugh, CEO of NJSNA, commented, "collaborative practice allows nurses to practice nursing and physicians to practice medicine."

*Miriam Cohen is a consultant with the MIIX Healthcare Group, a consulting and management firm located in Lawrenceville NJ.*

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# HMO Accountability in New Jersey

*Congressman James Saxton and Gerald S. Flanagan*

For most New Jerseyans, health care is not something we think about as we commute to work in rush hour traffic, shop for groceries, or shuttle the kids off to school. Although it is something that all of us carefully consider in the benefits package of a job, it is potentially something far more important than another benefit. In times of need, when a family member becomes sick or suddenly injured, we expect that our health care insurance will be there for us without question or delay. For a growing number of us, we have found that this trust has been misappropriately placed.

New Jersey's health care system is at a critical crossroads. As health maintenance organizations (HMOs) and other large health care providers further dominate the health care landscape, profit margins, not the Hippocratic oath, are all too often the bottom line in medical decisions.

As a result, patients' rights, doctor autonomy, and therefore the quality of health care suffers. Too many New Jersey health care consumers are denied access to the ser-

vices they need and the quality care they deserve. Their lives and well-being are put in jeopardy.

Unfortunately, New Jerseyans are all too familiar with the shortcomings of our managed care system. As a result of the high-profile financial ruin of two of the state's largest HMOs last spring and the resultant loss of health care for 200,000 New Jerseyans, the state legislature has initiated a process to review the shortfalls of the system. The state's powerful HMOs and health insurers are prepared to battle any and all reforms with their army of lobbyists and ever-increasing efforts to sway legislators.

HMOs and managed care have much room to reduce costs for health care consumers. However, some basic ground rules must be laid to ensure that patients receive the quality and scope of care they need and deserve.

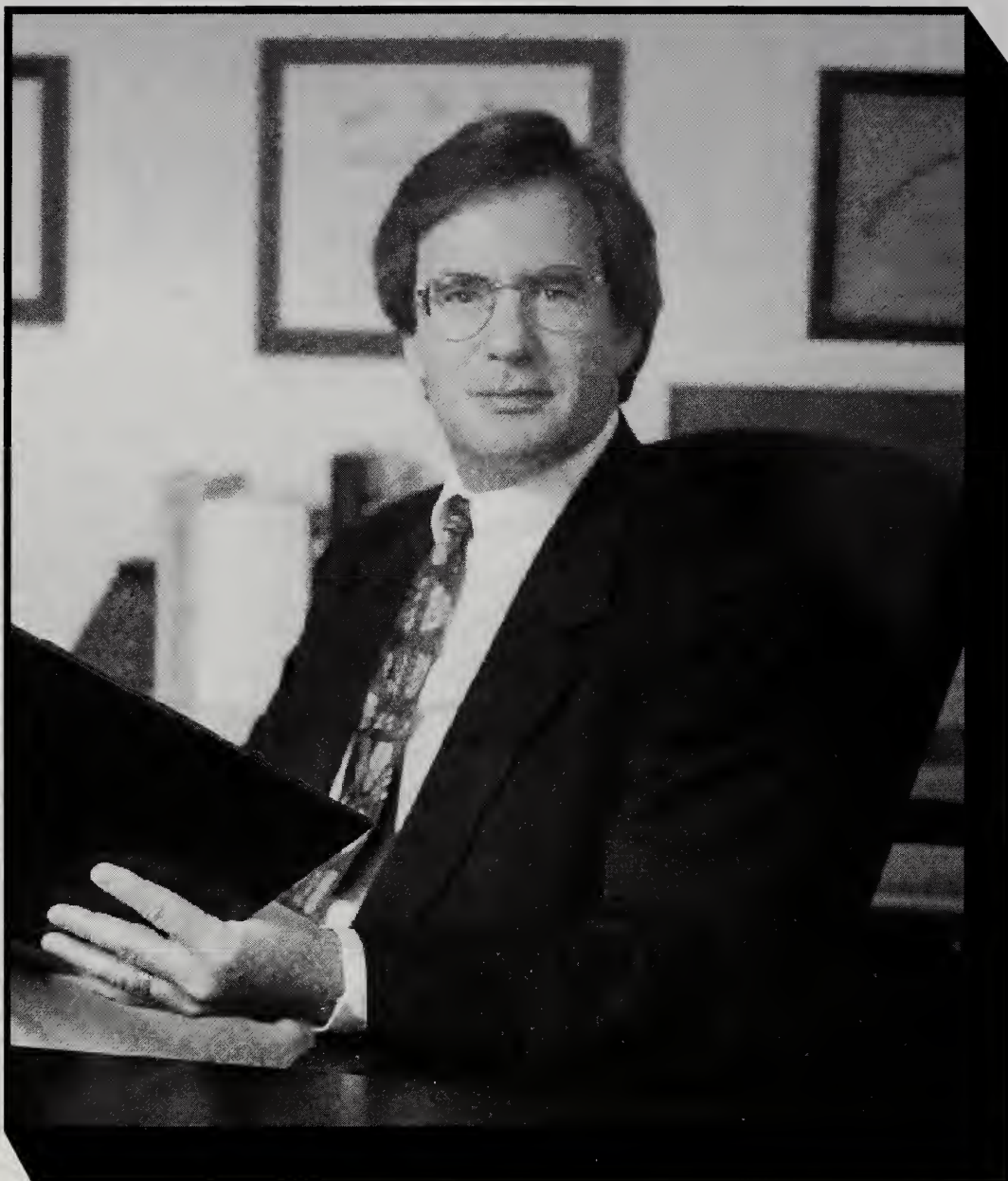
Federal legislation passed in 1974 has been misused by HMOs as a shield to protect against medical malpractice liability. The US House of Representatives has begun to open the door to greater health care

consumer protection with the Patients' Bill of Rights legislation. The most likely outcome of this congressional action is that states will be given the express right to adopt laws to make HMOs more accountable. Already, several states, including Texas and California, have taken steps to adopt measures to close the HMO liability loophole.

New Jersey has a great opportunity to adopt HMO accountability legislation. This law would send a powerful message to health insurers: if they act in such a way that delays or denies medically necessary care, they will be held accountable. This simple mandate will make HMOs far more responsive to patients' needs by putting proper care above profit margins.

*James Saxton is the congressional representative from New Jersey's 3rd Congressional District, which extends from the Delaware River in Burlington County to the Atlantic seashore in Ocean County and includes a few places in Camden County. Gerald S. Flanagan is a health care advocate with New Jersey Public Interest Research Group (NJPIRG) in Trenton.*





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# MSNJ Alliance: Looking Back on the Past Year

Gwen A. Jacobs

**T**he MSNJ Alliance has had a busy year working on legislation, community projects, health care outreach, and fund raising.

We have tried to raise a unified voice with that of the American Medical Association to champion sound health care legislation. The Alliance held a health care advocacy seminar to foster better understanding of the problems facing medicine and support better legislation. We have worked hard to ensure that legislation such as the Patients' Bill of Rights will reflect our needs as well as the needs of all our citizens. We have written letters, made phone calls, met with members of the NJ Senate and Assembly, lobbyists, and administrators to foster grassroots support for serious issues. We have urged patients to contact their legislators when their HMOs have denied services that physicians prescribed. The efforts of all our members nationally, on a grassroots basis, contributed to the ultimate success of the tobacco settlement.

The teen health seminar is our most extensive and important outreach program. This year we had two sessions, one in central Jersey and the other at the University of Medicine and Dentistry of New Jersey in Stratford, detailed in the June issue of *New Jersey Medicine*.

We are currently soliciting used cellular phones for battered women's shelters. These phones are reprogrammed so that the only number that can be called is 911. They are distributed to women considered "at risk" by their shelters. This campaign has now reached a nationwide level. We're proud that the MSNJ Alliance was one of the states at the forefront of this life-saving program.

We have assisted the Physicians' Health Program by "adopting" several of the neediest families and have provided food, clothing, toys, and monetary donations to these families.

We have run antiviolence campaigns with publications and booklets in our schools. Essex County enlisted the aid of Shoprite to distribute flyers in 185 of their stores throughout the state. Union County has been highlighted nationally for its progressive role in counteracting violence in the schools. Ocean County launched a massive

antiviolence program for their schools and adapted the SAVE logo to Students and Staff Against Violence Everywhere. Still other counties delivered antiviolence bookmarks to schools and health care literature to libraries, stores, and physicians' offices.

The Alliance has raised more than \$12,000 for Turkish earthquake relief. In addition, cartons of clothing and toys were shipped and distributed to 40 homeless orphaned children who were placed in temporary foster homes.

We have supported the Breast Cancer Research Stamp through local post offices. This was the first stamp in history to have its net proceeds from sales earmarked for research and has raised more than \$10.9 million dollars.

Each year we raise funds for our medical schools, scholarships and loans for medical students, and research for orphan diseases through the AMA Foundation. Atlantic County and other counties have raised funds for nursing scholarships.

Morris County has inserted "Friends Don't Let Friends Drive Drunk" cards into tuxedo pockets at formal rental shops and corsages at florists for high school prom nights.

Warren County has distributed Medi-file wallet-sized cards listing all the medications a patient is taking so that emergency room physicians and other health care personnel can be aware of potential interactions of the patients' medications.

The Alliance is actively campaigning to educate the public about the lasting legacy of organ donation. We are proud to join the 50,000 Alliance members across the country to back such a noble and life-prolonging cause. We have raised the awareness and acceptance of organ donation throughout our state with the distribution of donation cards and pins.

We have actively solicited members for MSNJ by physically recruiting memberships at both NJ medical schools, arranging joint meetings with the county medical societies, requiring spousal membership as a prerequisite for becoming an officer or delegate in our organization, and encouraging various family social events.

*Gwen Jacobs was MSNJ Alliance president for the year 1999-2000.*



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# A Short History of Medical Ethics

A Short History of Medical Ethics  
 Albert R. Jonsen  
 New York, Oxford University Press, 2000  
 148 pp., \$34.95  
 ISBN: 0195134559

Major innovations in medical practice have stimulated a greater awareness of the moral foundations on which our conduct as health care professionals is based. Life-sustaining technologies and organ transplantation force us to redefine the moment of death. Molecular biology and genetics give us information about the risk of disease not yet apparent and raise compelling issues of confidentiality. Problems with the financing and delivery of medical care threaten the sanctity of the doctor-patient relationship, disturb the equitable distribution of services, lead to increasing regulatory influences, and limit opportunity and choice.

These challenges are felt acutely today. But in truth they were no less acutely felt in the past. This book offers a glimpse into the long tradition of moral discourse about medicine and provides insights into the historical perspectives that have

shaped our attitudes toward the present-day delivery of medical care.

The author, Albert Jonsen, PhD, professor emeritus of ethics in medicine at the University of Washington School of Medicine, begs the reader's pardon for producing a "short" and, by historical standards, perhaps incomplete and superficial study. Nevertheless, this 120-page book contains a remarkable content of fascinating and insightful information that can be easily read and readily digested by the busy practitioner wishing to understand the historical relevance of the ethical underpinnings of the medical profession.

Jonsen begins by defining the historical elements of medical ethics: decorum, the character or quality of the moral person; deontology, the duties or obligations that constitute a moral life; and politic ethics, the relationship between individuals and their community. These elements perhaps translate into the

principle cornerstones of ethics as viewed today: beneficence, non-maleficence, and social justice.

The roots of medical ethics in Western culture began approximately five centuries before the common era, extending from the time of the Greek physician Hippocrates through the time of the Roman physician Galen. This period is marked by a series of about 70 treatises, known as the Hippocratic Collection, a medley of scholarly works written with the intent to explain the nature and course of disease, the means of healing, and the ways physicians should behave as they apply their skills. Emphasized are the values of wisdom, comportment, discretion, service, and responsibility.

Dr. Jonsen next moves into the medieval period, from the 5th to the 14th centuries, a period characterized by the growth and influence of the Christian faith, and explains how theological and ecclesiastical



influences shaped the ethics of medicine. He recalls the gospel of Jesus, who is described as "a miraculous healer of the sick and who commanded his followers to attend the sick." The early Church clearly endorsed the practice of medicine and encouraged care of the sick as a work of charity. This provided the basis for a strong deontology. Decorum, too, was stressed, in such monastic medical manuscripts as *Decorum and Law*, in which physicians are admonished to be studious and of good moral character.

Beginning in the 6th century and later in the 12th, the work of Jewish scholars and the establishment of Islam provide further basis for the cultural and religious underpinnings of medical practice. God is recognized as the healer, but humans are the agents to intervene.

Later, in the late 12th and early 13th centuries, the growth and development of the Holy Roman Empire would emphasize the importance of education and supervision of physicians. (Was this the earliest example of "managed care"?)

Political ethics was fostered by the guilds, social institutions that flourished across Europe from the 10th to the 15th centuries.

An interesting contrast is described between Western medicine and that of the Orient. In China and India, medical morality and practice remained a deontology

rooted in religious and philosophical beliefs and a decorum of polite and gracious behaviors as contrasted with the West, which had a strong social fabric and organization.

Through the Renaissance and Enlightenment, the growth of medical ethics was strongly flavored by the development of social commerce, the great pandemics of bubonic plague and syphilis, scholarship, and political discourse. In 18th-century England, medicine was viewed as a learned and "gentlemanly" profession.

The author then traces the rich history of American medicine, with its beginnings in the ethical debates concerning the experiments with smallpox inoculation and the establishment of medical societies. Physicians in New Jersey organized one of the earliest of these in 1766 and immediately promulgated a code of ethics, stressing learning and respecting consultation only with learned colleagues.

During the mid-1800s, independent state societies came together to form the American Medical Association, not without controversy and contentiousness, but with a commitment to a new political ethics for the profession, laying the foundation for an ethical code to govern professional conduct and shape attitudes toward relationships with patients, confidentiality, and duty to society.

Today, as we turn our attention more and more to palliative care and the control of pain, it is curious to reflect on the earlier attitudes, widely held at the time, that pain was a stimulus that promoted wound healing and cure and that elimination of pain would, in the opinion of many competent physicians of the time, retard and even prevent healing. The introduction of anesthesia created debates about benefits and risks, leading to increasing rationalization and objectivity in the assessment of new technologies.

The decades following World War II featured a series of events that have shaped our current thinking and attitudes: the Nuremberg trials, the discovery and understanding of DNA, the development of organ transplantation, the modern pharmacopoeia, the Tuskegee revelations, *Roe v. Wade*, Karen Ann Quinlan, and the AIDS epidemic.

In the latter 20th century, these events culminated in the modern discipline of bioethics now recognized as an integral branch of practical or applied philosophy and a valuable adjunct to health policy and medical practice.

Concise but comprehensive, thorough yet readable, this well-written book is a stimulating compendium of the historical and cultural imperatives that serve as the infrastructure linking scientific advances to human and environmental values.

Alan J. Lippman, MD



## PEOPLE IN THE NEWS



Louis E. Baxter,  
Sr., MD

The Physicians' Health Program of MSNJ was recently represented at the Annual Meeting of the American Society of Addiction Medicine by **Louis E. Baxter, Sr., MD**, medical director.

Dr. Baxter serves as cochair of the Ruth Fox Course and was this year's course moderator. Dr. Baxter is the chair of the Cross-Cultural Committee and a member of ASAM's Membership Committee, Committee on Forensic Medicine, Nominating Committee, and the Awards Committee. He is also a Fellow. He presented Forensic Issues in Physicians' Health and was course director of Cultural Competence in Addiction Medicine.



Lynn Helmer,  
MD, FACP

**Lynn Helmer, MD, FACP**, of Haddonfield has been appointed vice president of medical affairs at Shore Memorial Hospital in Somers Point.

**Mary T. Herald, MD**, of Westfield has been elected to a second term on the Board of Regents of the American College of Physicians-American Society of Internal Medicine.

Monmouth Medical Center, an affiliate of the Saint Barnabas Health Care System, announced that the

following people have joined its medical staff: neonatologist **Diane Attardi, MD**; orthopaedic surgeon **David Chalnack, MD**; internist **Brian Incremona, MD**; and pediatrician **Moshe Levy, MD**.



Laurene DiPasquale,  
MD

**Laurene DiPasquale, MD**, has been installed as the 134th president of the Bergen County Medical Society. Dr. Pasquale, a pulmonary specialist, is a board-certified internist at Pascack

Valley Hospital in Westwood.

The New Jersey Hospital Association (NJHA) presented its Distinguished Service Award to **Dick Oths**, president and CEO of Atlantic Health System in Morristown. The NJHA Special Recognition Award was presented to US Rep. **Robert Menendez**, who represents the 13th congressional district.



J. William Van Dyke

Freeholder **J. William Van Dyke** of Midland Park was honored by West Bergen Mental Healthcare for his leadership, dedication, and efforts at ensuring increased funding for community mental health in Bergen County.

**Karl Kirby**, a third-year student at the University of Iowa College of Medicine, was awarded first prize in the new Humanism in Medicine Essay Contest sponsored by the

Arnold P. Gold Foundation in Englewood.

**Jennifer L. Waxler, DO, FACOEP, FACEP**, was recently presented with the NJ American College of Emergency Physicians Emergency Medical Services award for chairing the coalition that helped to pass the primary seat belt law in New Jersey. Dr. Waxler is chair of the emergency department and director of emergency services at Capital Health System in Trenton.



Robert P. Wise

**Robert P. Wise**, president and CEO of the Hunterdon Healthcare System in Flemington, was recently named chairman of the board of the New Jersey Hospital Association.

**Seth Gavin Derman, MD**, and **Althea M. O'Shaughnessy, MD**, recently received subspecialty certification in reproductive endocrinology from the American Board of Obstetrics and Gynecology, Division of Reproductive Endocrinology and Infertility. Both are obstetricians and gynecologists at Capital Health System in Trenton.

**David B. Warheit**, a research fellow at E.I. du Pont Nemours' Haskell Laboratory in Newark DE and an inhalation toxicology scientist, received the eighth annual Robert A. Scala Award for Leadership in Toxicology from the Environmental and Occupational Health Sciences Institute, based in Piscataway.



## IMPROVING CANCER CLINICAL TRIALS

Every year, 20,000 patients participate in the clinical trials sponsored by the National Cancer Institute (NCI), the best method for advancing cancer care. But it still takes too long to answer important treatment questions.

That's why a fundamental change is under way in how the NCI develops, reviews, conducts, and supports clinical trials. The revitalized system is more flexible and more inclusive, inviting input from basic and clinical researchers, community and research oncologists, patients and families, and every group with a commitment to improving cancer care.

The oncology community and anyone else with an interest in clinical trials can explore a Web feature describing the new system at <http://cancertrials.nci.nih.gov/system>.

The new initiatives are divided into five categories:

- Broadening access—Opening clinical trials to more physicians and patients will mean quicker answers to vital cancer research questions.
- Generating new ideas—Canvasing a broad range of basic and applied scientists from both academia and industry will cast a wide net for the most promising new therapies.
- Educating and communicating—Reaching out to physicians and patients will bring more people into the clinical trials system and reinforce the message that clinical trials are critical.
- Streamlining procedures—Reducing paperwork and consolidating procedures will ease clinical trial participation for physicians while maintaining safety and quality.
- Automating data systems—Virtually every component of the new system will be online.

## MONMOUTH UNIVERSITY OFFERS SCHOOL NURSE CERTIFICATE

Monmouth University has announced that the Marjorie K. Unterberg School of Nursing and Health Studies has received approval from the New Jersey Department of Education to offer a school nurse certificate program. The program will be available in the fall of 2000.

## VIRTUA HEALTH NAMED REGIONAL ARTHRITIS CENTER

Virtua Health has been named by the state Department of Health as the Southern New Jersey Regional Arthritis Center at Virtua Health. The Arthritis Quality of Life Initiative includes the funding of two regional arthritis centers (the other is Atlantic Health System Hospital Corporation) and a statewide conference and resource directory.

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## LOTS OF HEALTH CARE SITES—HOW MANY DOCTOR VISITORS?

A recent report posted on [www.forrester.com](http://www.forrester.com), by Forrester Research in Cambridge MA, is intriguingly entitled "Why Doctors Hate the Net." It points out a discrepancy between the goals of health care Web site organizations and their physician marketplace. Specifically, the report claims that Web site vendors of medical information, supplies, and pharmaceuticals, among others, have vastly overestimated the number of physicians who are incorporating these sites into their daily practice. Until physicians are sure that the electronic tools being offered will save time and money and truly do improve quality of care, they will be slow to implement them. Nevertheless, the article does foresee the migration of physicians to the Web over time.

According to a recent issue of *Medicine on the Net*, however, one exception to this trend is attainment of CME. Feeling both time and money pressures, more and more physicians are turning to Web-based CME offerings. Physicians interviewed for the article pointed out that at \$10 to \$25 per credit hour, Web CME has a huge

advantage over just the travel expenses incurred for traditional courses, not to mention the courses themselves. For more information, go to [www.corhealth.com](http://www.corhealth.com). (Both of these sites require registration and offer free access for only a limited time.)

### NATIONAL BREAST CARE REGISTRY

Ethicon Endo-Surgery, Inc., a Johnson & Johnson company, announced the launch of a confidential Web-based service that helps doctors manage and track information about breast care patients nationwide. The National Breast Care Registry links physicians and facilities for national benchmarking of breast disease, capturing detailed biopsy data and outcomes. In addition, the service reminds office personnel when a patient is due for follow-up, provides individualized and comparative reports, and helps physicians meet accreditation requirements. To enroll, call (800) 380-8066 or visit [www.breastcareregistry.com](http://www.breastcareregistry.com).

### ADVOCACY RESOURCE CENTER LAUNCHED

The AMA has launched a Web site for its Advocacy Resource Center. Available to members only, the site features materials and information on advocacy campaign issues, including

prompt-pay laws, managed care accountability, external reviews, joint physician negotiations, and scope-of-practice issues. Resources include legislative materials, model communications tools, legal information, information for physicians, and state legislative updates on other key issues facing organized medicine. Advocacy discussion forums will encourage the daily exchange of information among peers. For more information, go to [www.ama-assn.org\ARC](http://www.ama-assn.org\ARC).

### ELECTRONIC ADMINISTRATIVE SERVICE ORGANIZATION

Med on Web ([www.medonweb.com](http://www.medonweb.com)), billing itself as "the cure for infectious administrivia," provides outsourcing of many business functions, including eligibility confirmation, transcription, claims management, claims settlement, electronic banking, and others. Med on Web is betting on the outsourcing arrangement being more attractive to physicians (allowing them to do "nothing but what they really want—practice medicine") than having to buy and learn new software and systems. The company is promising to pay doctors within 72 hours of transcript approval. The cost is reported to be 15% to 20% of per-claim collections.



## **NEW HEALTH CARE CAREER WEB SITE LAUNCHES**

VitalCareers.com has launched on the World Wide Web. The site will serve all aspects of the \$700 billion health care industry, including physicians, nurses, administrators, medical students, and allied health professionals, as well as pharmacists and technicians. In support of the ongoing educational needs required by many health care professionals, VitalCareers.com will offer a \$2,000 grant each month to a

randomly selected registrant. All registrants are eligible. The service is free to candidates seeking employment. For employers, there is a basic, one-month service fee for each opportunity listed. During that time, employers can view online resumes and contact candidates via e-mail. Another fee-based option for employers includes submitting requests for specific candidates based on such criteria as specialty training and skills, years of experience, and licensure. VitalCareers.com can be

reached at (310) 441-9676. The Web address is [www.vitalcareers.com](http://www.vitalcareers.com).

## **ENHANCED ENDORSED-VENDORS PAGES ON MSNJ.ORG**

The pages devoted to MSNJ-endorsed vendors have been enhanced to include more information about the programs, services, and products available and now offer click-through convenience to the vendor sites. Take a look under Member Programs, Endorsed Vendors, at [www.msnj.org](http://www.msnj.org).

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# CALENDAR

## E V E N T

## D A T E

## L O C A T I O N

### J u l y

|                                                                                              |                  |                                         |
|----------------------------------------------------------------------------------------------|------------------|-----------------------------------------|
| <b>International Conference on Alzheimer's and Related Disorders</b>                         | July 9-14        | Washington DC, (312) 335-8700           |
| <b>13th International Symposium on Treatment of Leukemia, Lymphoma, and Cancer</b>           | July 14-18       | New York NY, Imedex USA, (770) 751-7332 |
| <b>AMA Teleconference: "Building Your Group Practice Web Site is Easier Than You Think."</b> | July 28          | 1:30 PM ET, (312) 464-4539              |
| <b>Update and Intensive Review in Internal Medicine</b>                                      | July 30-August 5 | New York NY, (212) 781-5990             |

### A u g u s t

|                                                                       |              |                                 |
|-----------------------------------------------------------------------|--------------|---------------------------------|
| <b>Frontline Healthcare Worker Safety: Partnerships in Prevention</b> | August 6-8   | Washington DC, (678) 781-5241   |
| <b>Annual Meeting of the National Medical Association</b>             | August 12-15 | Washington DC, (202) 347-1895   |
| <b>22nd Annual Meeting Cognitive Science Society</b>                  | August 12-15 | Philadelphia PA, (734) 764-4253 |

### S e p t e m b e r

|                                                                          |                 |                                                                    |
|--------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------|
| <b>Advanced Seminars in Ultrasound Diagnosis</b>                         | September 8-10  | Crown Plaza Manhattan, New York NY, (914) 921-5700                 |
| <b>Substance Abuse in Health Professionals, Treatment of Diabetes</b>    | September 13-14 | Atlantic City, (800) 940-5860                                      |
| <b>American Association of Electrodiagnostic Medicine Annual Meeting</b> | September 13-16 | Philadelphia Marriott, Philadelphia PA, (507) 288-0100             |
| <b>Women with Disabilities: Quality of Care, Quality of Life</b>         | September 15-16 | Philadelphia PA, (610) 519-6828                                    |
| <b>Certified Coding Specialist—Physician-based Exam</b>                  | September 16    | American Health Information Management Association, (312) 233-1160 |
| <b>World Congress of Gynecology and Obstetrics</b>                       | September 17-22 | Washington DC, (514) 286-0855                                      |



## E V E N T

## D A T E

## L O C A T I O N

## S e p t e m b e r

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|---------------------------------------------------------------------|------------------------|-------------------------------------------------------|
| <b>New Developments in Retinal Disease and Vitreous Surgery</b>     | September 22           | Baltimore MD, (410) 328-5934                          |
| <b>American College of Radiology Annual Meeting</b>                 | September 23-27        | New York Hilton & Towers, New York NY, (703) 716-7545 |
| <b>Lung Transplantation—Update</b>                                  | September 26           | Mount Sinai Hospital, New York, NY, (212) 241-3079    |
| <b>American College of Emergency Physicians Scientific Assembly</b> | September 28-October 8 | Philadelphia PA, (214) 550-0911                       |

## O c t o b e r

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|--------------------------------------------------------------------------------------|---------------|---------------------------------------------------------|
| <b>Clinical Endocrinology—Update 2000</b>                                            | October 1-4   | Philadelphia PA, (301) 941-0200                         |
| <b>Biocontaminants and Biological Production Issues</b>                              | October 3-4   | Hilton Alexandria Hotel, Alexandria VA, (617) 630-1300  |
| <b>American Society of Human Genetics</b>                                            | October 3-7   | Philadelphia PA, (301) 571-1825                         |
| <b>50th American Society of Bariatrics Physicians</b>                                | October 3-7   | Washington DC, (303) 770-2526                           |
| <b>Lymphoma and Myeloma 2000</b>                                                     | October 5-7   | New York NY, (770) 751-7332                             |
| <b>3rd Annual Symposium on Alternate Bearing Surfaces in Total Joint Replacement</b> | October 6-7   | Westin Hotel, Philadelphia PA, (215) 898-6400           |
| <b>Seminar of Legal-Medical Issues</b>                                               | October 10-23 | Colonial Cruise departs New York NY, (800) 521-0076     |
| <b>1st International Geriatric Palliative Care Congress</b>                          | October 11-14 | New York NY, (514) 286-0855                             |
| <b>The Fetus and Newborn: State-of-the-Art Care</b>                                  | October 11-14 | Crystal Gateway Marriott, Washington DC, (925) 828-7100 |
| <b>Contemporary Nuclear Cardiology</b>                                               | October 12-14 | Heart House, Bethesda MD, (301) 897-2694                |
| <b>8th Conference on Radioimmuno-detection and Radioimmunotherapy of Cancer</b>      | October 12-14 | Princeton NJ, (973) 844-7007                            |
| <b>Managing Respiratory Diseases</b>                                                 | October 13-15 | Marriott Marquis, New York NY, (800) 421-3756           |

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| <b>Cardiovascular Imaging Conference</b>        | October 13-15             | Philadelphia PA, (800) 373-2204                                    |
| <b>American College of Emergency Physicians</b> | October 21-24             | Philadelphia PA, (800) 798-1822                                    |
| <b>Fundamentals in Critical Care Course</b>     | October 26-27             | Danville PA, (717) 531-6483                                        |
| <b>American College of Rheumatology</b>         | October 28-<br>November 2 | Pennsylvania Convention Center,<br>Philadelphia PA, (404) 633-3777 |

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| <b>American Society of Cytopathology</b>                       | November 7-11              | Philadelphia PA, (302) 429-8802                         |
| <b>Chemotherapy Foundation Symposium XVIII</b>                 | November 8-11              | Sheraton New York, New York NY,<br>(212) 241-6772       |
| <b>5th New Jersey Symposium on Biomaterials<br/>Science</b>    | November 9-10              | Somerset NJ, (732) 445-0488                             |
| <b>Back Pain and Disability—Unraveling the<br/>Puzzle</b>      | November 30-<br>December 2 | New York Medical Center, New York NY,<br>(800) 872-3105 |
| <b>Interpretation and Treatment of Cardiac<br/>Arrhythmias</b> | November 30-<br>December 2 | Philadelphia PA, (301) 897-2694                         |

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| <b>Dermatology for the Nondermatologist</b> | December 15-17 | Grand Hyatt, New York NY, (800) 421-3756      |
| <b>New York Cardiovascular Symposium</b>    | December 15-17 | New York NY, (301) 897-2694                   |
| <b>Lower Genital Tract</b>                  | December 17-20 | Marriott Marquis, New York NY, (215) 542-3838 |



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**Title page.** The title page should include the full names, degrees, and affiliations of all authors, and

the name and address of the author to whom correspondence should be sent.

**Abstract or summary.** The author(s) should submit a 30-word abstract to be used at the beginning of the article.

**Text.** Articles should be a minimum of 500 words and a maximum of 3,000 words; check with the editors if the word count deviates from this.

**References.** References should not exceed 35 citations and should be cited consecutively by superscripted numbers at the end of the sentence. The style of *New Jersey Medicine* is that of *Index Medicus*: 1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

**Illustrative material.** Tables and graphs should be presented at the end of the article. Line art should be camera-ready or on disk. Illustrations should be of professional quality, black and white glossy prints. The name of the author, figure number, and top of the figure should be clearly marked on the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission signed by the subject or responsible person must be included with the photograph. Materials taken from other publications must give credit to the original source. Generic names should be used with proprietary names indicated parenthetically with the first use of the generic name.

**Copies of journal.** All authors will be sent one copy of the journal upon publication. Up to three complimentary copies may be requested before the journal goes to press (the first day of the month before publication). Additional copies thereafter must be requested before the journal goes to press and cost \$7.50 each. Subjects of the *New Jersey Medicine Interview* will be sent 10 copies of the journal upon publication. Up to 25 complimentary copies may be requested before the journal goes to press (the first day of the month before publication). Additional copies thereafter must be requested before the journal goes to press and cost \$7.50 each.



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# Looking for Collar Buttons

Sanford M. Lewis, MD

**M**y eighth-grade teacher delighted in making her point obliquely. She apparently succeeded in assessing the sophistication level of her students, since I have never forgotten one of her lessons. It seemed—at the time—a hilarious story about a man who lost his collar button near the bed. When his wife found him searching near the window, she asked why. He answered, "The light's better over here."

A 1982 article in the *New York Times* described genetic research at the National Cancer Institute, representing, perhaps, the first glimmer of what has become a major thrust in genetic-viral experimentation. The account stimulated conjecture about the direction in which we have been using our searchlights, then and now. A strange question emerges: Is the migration of a virus from animal to animal a hitherto unrecognized form of reproduction rather than simply a type of infection? Have we stumbled on a cosmic plan of miscegenation?

Physicians have wondered why so many viral infections are quite mild and of brief duration as compared with bacterial or protozoan disease. Yet mild viral infections in pregnancy often produce severe birth defects, unlike bacterial illnesses. We have become well aware that viruses residing in one species can carry genetic material and invade or be injected into individuals of an unrelated group in such a manner as to induce genetic change transmissible through ensuing generations. The sudden gaps and rapid transmu-

tations in an otherwise gradual and organized Darwinian evolutionary process may have an added explanation.

As the bee migrates to ensure species preservation in a macroscopic sense, so does the sperm travel for a similar purpose, albeit microscopically. Beyond this familiar mechanism, however, we may begin to see the faint outlines of a biological thrust aimed, not at a given species, but at all. Is this evolution's umbrella insurance policy, extending the concept of survival of the fittest to survival overall, through the far more rapid (re)production of new candidates for the race to eternity?

Perhaps we will find that the viral voyage is no more an infectious event, at least when successful, than the better understood journey of the sperm, which also has its failures. Perhaps neoplasia, so often associated in the laboratory with viral traces, is a corollary of this process, with the rapid embryonic type of cellular growth leading aberrantly to disease rather than "planfully" to a new or transmuted species. There is now abundant evidence that viral vectors, effectively supplied with encoded genetic fragments, are potential powerful allies in the destruction of malignant processes.

Are we really encountering yet another manifestation of the protean sexual drive capable of producing, just as in its more familiar form, the greatest rewards and the most profound tragedies of the biologic journey?



# NEW JERSEY MEDICINE

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## Aetna's aegis anaerobic

Aetna US Healthcare, which covers about two in five New Jersey HMO members, is again coming under local fire. At press time, Aetna CEO William H. Donaldson's promise to the Connecticut State Medical Society of a "sea change in our corporate attitude toward working with your profession" had not yet lapped the shores of the Garden State.

Responding to Aetna's intransigence on physician contract issues, MSNJ president Walter J. Kahn, MD, has publicly criticized the Pennsylvania-based health plan. Instead of using its market dominance to enhance the physician-patient relationship and improve patient care, declares Dr. Kahn, Aetna "has done quite the opposite."

A key issue is the "all products clause," under which Aetna can force a physician who agrees to participate in one Aetna plan to participate in all Aetna plans. Further at issue are forced acceptance of new patients, physician profiling practices, and lack of

financial support for disease prevention. Clinical areas, including drug formularies and restrictions on psychiatric care, also have been subject to MSNJ's vehemently expressed concerns.

**State Role.** Relations between Aetna and New Jersey physicians may come to a head in August, when a consent order between the behemoth HMO and the state becomes one year old. The order permitted Aetna's purchase of Prudential Health Care to go forward, with many conditions.

But MSNJ leaders are not satisfied with the pattern of state supervision of Aetna. For example, a dispute resolution program mandated under the consent order was implemented late and is far weaker than was anticipated.

Supporting MSNJ's demands for improved behavior by Aetna, the American Medical Association has written Governor Whitman. The AMA letter is reproduced later in these pages.

## PHYSICIAN IMAGE

New national survey data shows continuing credibility of physicians in a managed care environment. The Center for Studying Health System Change released a *Data Bulletin* reporting that 70% of insured patients strongly agreed

**T**he Pew Charitable Trusts has learned that people have no clear idea of what constitutes public health but that they are concerned about environmental threats to health. Most respondents in a nationwide phone survey could not correctly identify protecting the population from disease or programs promoting healthy living for everyone as components of public health. However, air pollution, contaminated drinking water, food contaminated with bacteria, and toxic waste all were rated as having a "great deal" of impact on a person's health by more than half of the respondents. The *MMWR Weekly* discussed the findings.

that physicians put medical needs first; only 3% strongly disagreed.

In its 1998-99 Community Tracking Study of 59,000 individuals, the center further found that most respondents disagreed that doctors are influenced by insur-



ance company rules in making medical decisions. Interestingly, confidence in physicians' decisions rose with income level.

Another study showed that physicians' communication styles are a key determinant of vulnerability to malpractice suits, according to the newsletter *Loss Minimizer*. Writer Scott R. Berglund summarizes research showing "no significant difference in clinical competence between physicians who are sued and those who are not." Physicians help themselves by demonstrating that they are caring and understanding, by answering questions, and by furnishing information.

Berglund adds that "arrogance, or even the appearance of it, also hampers the likelihood of a successful defense." He concedes, though, that constructive measures by physicians to prevent errors and mistakes are difficult to take in today's litigation-crazed (our word) atmosphere.

## NEW CENTER

It's good news for New Jerseyans that Rutgers University's new Center for State Health Policy is embarking on a statewide family health survey. The center also has initiated publication of a newsletter, *CSHP News*. Summarized in the latest issue are results of a *Star-*

*Ledger* Eagleton poll, in which people said they were more worried about finding good-quality, affordable health care than finding enough money to retire, enough money to live comfortably, or decent affordable housing.

## TOBACCO FUNDS

Our state is not leading the pack in amount of tobacco settlement dollars allocated to tobacco control. In a recent compilation by the SmokeLess States National Program Office of the AMA, New Jersey was not listed among the states that are adhering to Centers for Disease Control guidelines for spending sufficient funds on tobacco control.

States shown to comply with the CDC recommendations are Hawaii, Indiana, Maine, Maryland, Minnesota, Mississippi, and Ohio. And several of these states have adopted legislation to fund their tobacco control programs for 10 to 25 years.

SmokeLess States is funded by the Princeton-based Robert Wood Johnson Foundation. MSNJ, which coordinates the New Jersey Breathes program chaired by Fred M. Jacobs, MD, JD, is one of two medical society grantees.

## GOVERNMENT CHANGE

Medicaid programs may be entering on hard times, as states

begin to drift away from the managed care principles that previously attracted them. In New Jersey MSNJ has formed a coalition to press for reasonable reimbursement levels for physician services under Medicaid. And the Center for Health Care Strategies at Princeton University has published a report showing that most Medicaid managed care plans across the country are losing money. According to the report, Medicaid-only plans fare better under the program than do plans that are predominantly commercial.

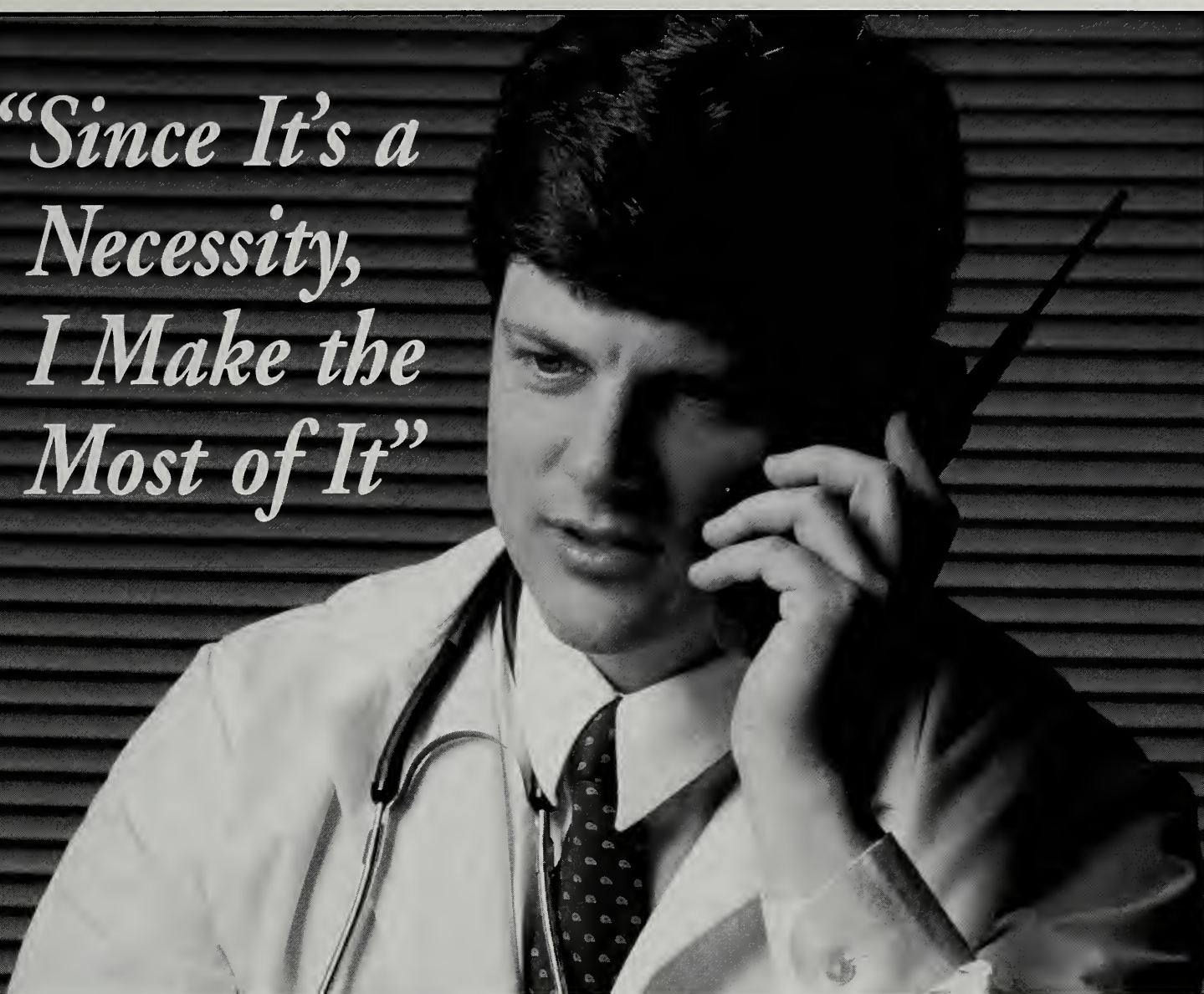
Karen L. Suter is the state's new Commissioner of Banking & Insurance. Ms. Suter succeeds her former supervisor, Jaynee LaVecchia (see *New Jersey Medicine*, January 2000, cover story), who was elevated to the state Supreme Court.

The new commissioner will face intense scrutiny over automobile insurance programs, as potential candidates gear up for the 2001 gubernatorial election. Already, she has been sued by HMOs angry about having to pay for one-third of the cost of health care claims still outstanding from the HIP and APPP bankruptcies of 1998. Sad, isn't it?

Neil E. Weisfeld



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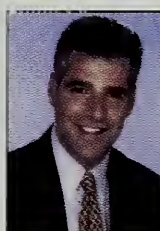
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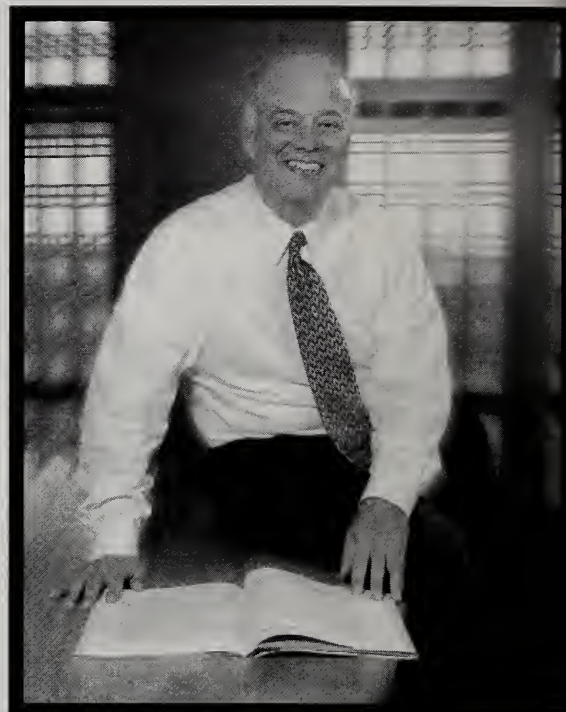
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## BREAKING THE CYCLE

At first glance, one might think there is no association between two articles in this issue of *New Jersey Medicine*. What would the Pima Indian children and youth with type 2 diabetes have in common with New Jersey youth who use tobacco products?

Type 2 diabetes among the Pima youth and children was first recognized almost 20 years ago. Currently, many of the Pima elders have passed the "point of no return" on their path to dreadful end-stage organ complications and early death from chronic poor control of diabetes. There are numerous barriers to breaking the cycle among Pima youth. We know most of them: cultural beliefs, denial, peer pressure, disinterest in health issues, the theory of "inevitability," the youthful belief in invincibility, poor communication between the young and their parents and elders, and lack of concern about personal appearance (obesity). Pima youth have five times the risk of acquiring type 2 diabetes than white youth. A strong family history of diabetes and obesity are common among Pimas and all American Indians. The key strategy is organized blood screening for diabetes of children and youth in pueblo and reservation health centers, churches, schools, and shopping malls. We must educate and increase awareness of the complications to high-risk families as regular tribal activities. Lifestyle changes must be taught: weight control, regular physical exercise, and avoidance of fatty junk food—lard and other calorie-laden, obesity-producing food.

The New Jersey Youth Tobacco Survey shows that the proportion of students currently using tobacco products increased by 128% for cigarette use between the 7th and 8th grades. Use of cigars and smokeless tobacco increased significantly between the 8th and 9th grades. If we convince children and adolescents not to start smoking, we stand an excellent chance of stemming the epidemic of smoking, since more than 80% of adult smokers started smoking cigarettes before they were 18. Convincing children to abstain from smoking is a formidable task because of opposing forces. A young person who lives with a smoker has twice the risk of becoming a smoker. A youth whose four closest friends smoke has a 66% chance of becoming a smoker. The New Jersey Comprehensive Tobacco Program will reach children in school and in the community. It will use the latest and best-proven methods available to fight this epidemic. Physicians can help by taking tobacco histories, encouraging all patients not to start smoking, and guiding smokers of all ages to use smoking-cessation programs.

With the interventions described above, there is hope of preventing Pima Indian children from living with obesity and diabetes. Similarly, there is a very good chance that, in New Jersey, we can stop tobacco use from being a pediatric disease.

*Arthur Krosnick, MD, and Leah Ż, Żjskin, MD*



## NEW JERSEY'S PHARMACEUTICAL INDUSTRY

New Jersey is the world center of the pharmaceutical industry and has been called "the cure corridor" and "the world's medicine chest." The pharmaceutical industry is a critical component of New Jersey's economy and a part of its culture and history. An outstanding resource for New Jersey, the pharmaceutical industry is one of the largest employers in the state and a magnet for highly educated, well-motivated professionals and scientists who contribute to their communities in many ways. Articles in this issue focus on various aspects of the industry.

Public awareness of the importance of the pharmaceutical industry to the state has been advanced by the HealthCare Institute of New Jersey (HINJ), an association of pharmaceutical and medical technology companies in New Jersey. Patrick J. Zenner, one of the founders of HINJ and its second chairman, is completing his term in that office just as we go to press with this issue. Mr. Zenner is also the president and CEO of Hoffmann-La Roche. He knows his industry, he knows New Jersey, and he has a fine sense of the importance of each to the other.

For the interview presented in this issue, *New Jersey Medicine* went to Mr. Zenner's office on the Hoffmann-La Roche corporate campus in Nutley. We found him to be a cordial and well-informed spokesperson for his company and the industry. He is enthusiastic about the concentration of the

pharmaceutical industry in New Jersey and its impact on the health and well-being of people all over the world. He is clearly proud of his own company as an employer and as a source of scientific research and innovation.

Also in this issue is a report on the pharmaceutical industry from William Tremayne, president of HINJ. He provides greater detail about the role of the member companies of HINJ in New Jersey's economy and in advancing research and the development of new drugs.

This is a role that New Jersey's pharmaceutical industry has filled for decades. In the medical history article in this issue, Dr. Henry Sherk notes that the drug companies in New Jersey rose to the task of providing sufficient penicillin for the allied forces in World War II. He further states that "New Jersey . . . is to pharmaceuticals what Michigan is to automobiles and what Silicon Valley is to computers."

Dr. Sherk's article reviews the career of Dr. Selman Waksman, the Nobel Prize-winning discoverer of streptomycin. Dr. Waksman was the founder and first director of the Institute of Microbiology at Rutgers University, which was renamed the Waksman Institute after his death in 1973. It is appropriate that Dr. Waksman should have performed most of his research in the state that is the center of the world's pharmaceutical industry.

*Paul J. Hirsch, MD; Patricia A. Costante; Bernard A. Rineberg, MD*

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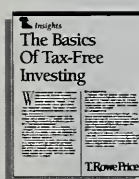
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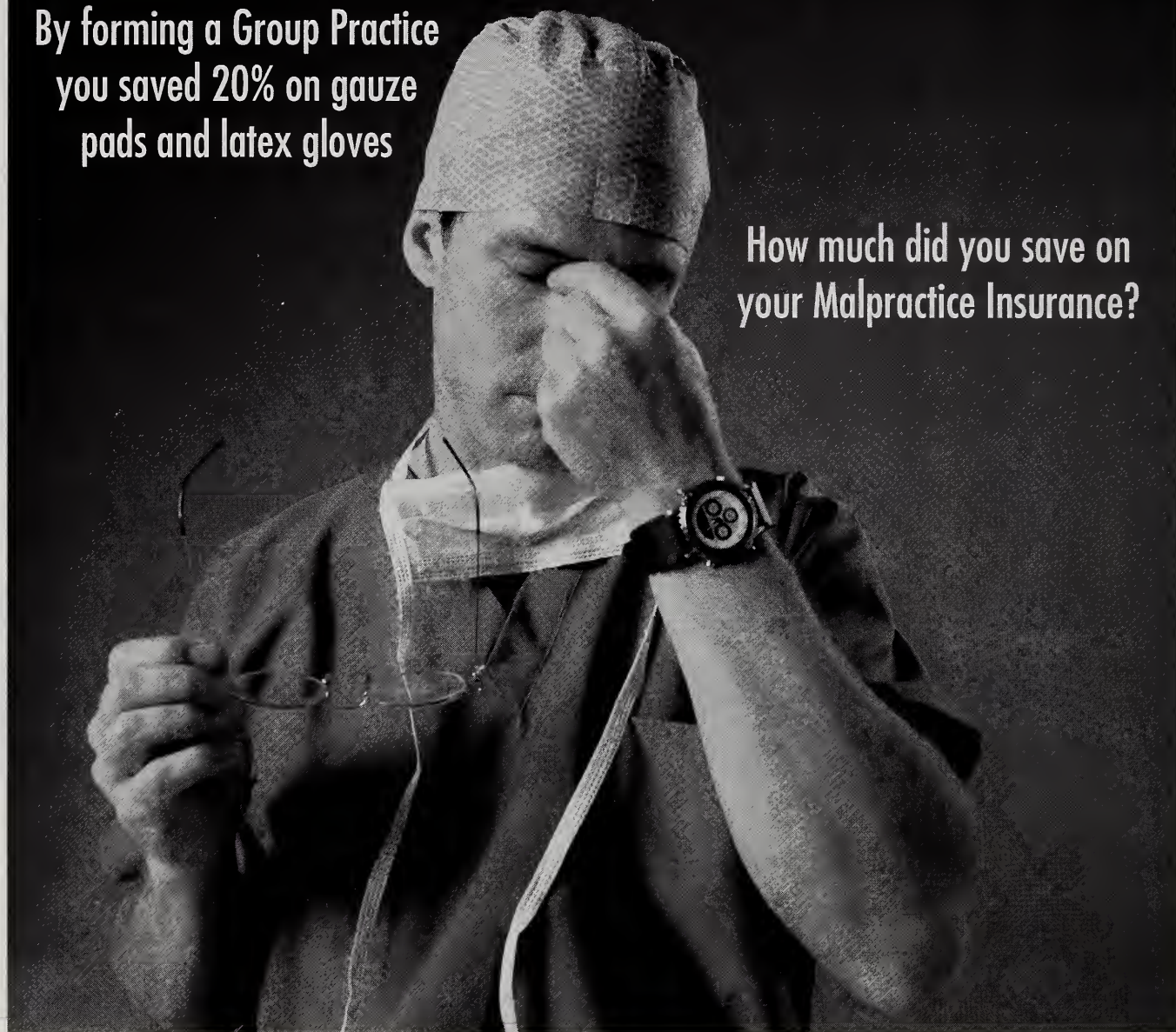
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## MELANOMA, DEFINED

Either the term *cutaneous melanoma* is used loosely, or the statistics quoted by James Goydos ("Prevention and Early Diagnosis of Cutaneous Melanoma," *New Jersey Medicine*, May 2000) that 46,000 new cases of cutaneous melanoma occur annually (the rate increasing about 5% per year) and a death rate of 20% are too inclusive. Almost every friend one meets at gatherings of the superannuated tells of having had a "melanoma" removed.

I realize that dermatologists commonly remove dark skin lesions, so that patients hear the term *melanoma* before the tissue has been submitted to the laboratory and that the laboratory diagnosis of melanoma may not always discriminate between intraepidermal cellular collections and those that have penetrated the basement membrane. Both are melanomas with different life histories, the former more dangerous and predictable than the latter.

Although the term melanoma classically means malignant melanoma, the term *benign melanoma* might be useful to distinguish excised lesions for statistical purposes.

Charles Harris, MD  
Island Heights NJ

*Dr. Goydos responds:* As pointed out in the references, the statistics that I quote in my article come from the *American Cancer Society: Cancer Facts and Figures—1998*, ACS, 1998. Backup material can be found in Landis SH et al., *Cancer statistics, 1998*, *CA Cancer J Clin*, 1998, 48:6-29. The term *cutaneous melanoma* as used in the article is specifically defined as per dermatopathological guidelines and refers to a malignant process involving the melanocytes of the skin. All true melanomas are malignant and the term *malignant melanoma* is redundant. There is no such thing as a *benign melanoma* and the term should not be used. The

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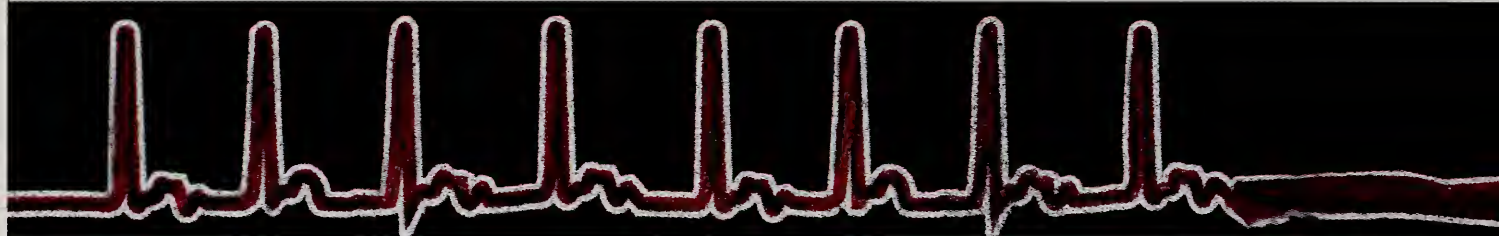
To submit a letter, e-mail ([info@msnj.org](mailto:info@msnj.org)) or mail your letter on disk to New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Letters should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgement. Letters may be published on MSNJ's Web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

American Joint Committee on Cancer (AJCC) is responsible for the development of staging criteria for all cancers, including melanoma. Melanomas that have not penetrated the basement membrane of the epidermis are defined as in situ (pTis) while melanomas that have penetrated the basement membrane are stratified according to their thickness and depth of penetration. All cutaneous melanomas start as in situ lesions. If left untreated or if treated inappropriately, all melanomas have the propensity to penetrate deeply into the dermis, invade the lymphatics and blood vessels, and spread to regional lymph nodes and distant sites. Melanoma is, in general, a very aggressive and deadly disease. However, if treated appropriately, most melanomas can be cured. It is very important that physicians screen their patients for cutaneous melanoma and if melanoma is suspected that they refer those patients to appropriate specialists. Furthermore, a patient who has had one melanoma (even an early, in situ lesion) is at an increased risk of developing subsequent melanomas and must be followed closely. ■



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# A Change for the Better

IS THE TERM ORGANIZED MEDICINE AN OXYMORON? GIVEN TODAY'S

ENVIRONMENT AND EMERGING PATTERNS, I'M AFRAID IT MIGHT BE.

*Walter J. Kahn, MD*

Everywhere we look in medicine, we see major concerns of multiple societies, duplication of services, disparate goals, and a high cost of multiple enrollments. The AMA Council of Long-Range Planning and Development researched these issues in depth and reported on its findings at the recent meeting in Chicago. I have sent this report to all our county societies for their review.

In response to this problem, societies at all levels are actively pursuing horizontal or vertical integration. One example of horizontal integration on the national level was the merger of the American College of Physicians with the American Society of Internal Medicine. At the state level, we see a collaborative effort among the Maine, New Hampshire, and Vermont medical societies, which are realizing significant cost savings through integration of services.

Such collaboration and sharing of services even extends further down to the county level, with notable success stories in California and Pennsylvania. Here in our state, the Somerset and Middlesex county medical societies serve as an excellent partnership model. Obviously, such an arrangement must be voluntary and the issues of dues, governance, and autonomy must be worked out to every-

one's satisfaction. It's a difficult job, but nothing worth doing is ever easy.

For a small county with a part-time executive or none at all, it is virtually impossible to help MSNJ address its many urgent concerns while maintaining day-to-day operations. As an alternative, Maryland has aggressively stepped forward with vertical integration of county medical societies with the state medical organization: MedChi. A motivating factor was that the average age of MedChi members was high and not getting any lower. Less than 16% of the state's physicians under the age of 50 are members.

An additional incentive for MedChi to integrate was to establish a common membership fee that was less than the current amount of combined state and county dues. To date, 13 of the 24 county societies have voluntarily participated, resulting in office and personnel sharing with greater economies of scale. The Minnesota Medical Association has undergone a similar integration.

So, what's going to happen here at MSNJ? Ernst & Young is currently performing a complete organizational study under the direction of Fred M. Palace, MD, chair of the Strategic Planning Committee. We expect to present the results of this study to membership in the near future.

One thing is for certain. Standing still in these fast-changing times is an option we can no longer afford. ■





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# The AMA to Gov. Whitman: Aetna US Healthcare Causing Serious Concerns

IN THIS LETTER TO GOVERNOR CHRISTINE WHITMAN DATED JULY 5, 2000,

THE AMA BACKS UP MSNJ'S STAND AGAINST THE STATE'S LARGEST HMO.

Dear Governor Whitman:

The AMA strongly supports your leadership in combating problems associated with tobacco use, delays in payments by health insurers and HMOs, HMO bankruptcies, and regulation of health insurers. I am impressed by your efforts, and I am personally pleased that you were the recipient of our 1999 national Nathan Davis award.

In light of your leadership, the AMA would like to alert you to our serious concerns about the lack of progress in addressing the behavior of Aetna US Healthcare in New Jersey through enforcement of the consent decree that Aetna and the state entered into on August 6, 1999. As you will recall, that decree permitted Aetna to purchase Prudential Healthcare and thereby increase its market share beyond a 40% penetration statewide. In several New Jersey counties, Aetna's dominance exceeds 60%. In July 1999, the AMA and MSNJ sent a joint letter to New Jersey Attorney General John Farmer outlining our concerns with the Aetna/Prudential merger, and the AMA continues to closely follow developments relating to implementation of the consent decree.

On June 23, 2000, AMA staff attended a meeting that we had expected would reveal significant progress. Participants included MSNJ president Walter J. Kahn, MD, Commissioner of Health & Senior Services (DHSS) Christine Grant, Commissioner-designate of Banking & Insurance (DOBI) Karen Suter, Commissioner of Human Services Michele Guhl, and several top regional executives of Aetna.

According to reports that I received, approximately one-half hour after arriving for the meeting at the scheduled time, the AMA and MSNJ participants were allowed to enter the conference room where everyone else had been meeting for some time. This was disconcerting, to say the least. Several of the topics suggested by MSNJ had been removed from the agenda. No demonstrable progress occurred on the remaining items, and MSNJ reports that there has been no follow-up contact.

During this meeting the AMA and MSNJ learned that a key element of the August 1999 consent decree—establishment of an alternative dispute resolution (ADR) mechanism—had just been implemented by Aetna and the state without any MSNJ input. MSNJ had already indicated to the AMA its concern that implementation of this element

was several months late and that Aetna's proposals were woefully inadequate.

The AMA strongly supports MSNJ's position, and we agree that certain components of the proposed ADR mechanism do not even come close to resembling the excellent requirements of a recent regulatory proposal of the DOBI, which you had announced at MSNJ's annual meeting on May 5, which MSNJ shared with us. For example, Aetna's approach as approved by the DHSS contains no external appeal mechanism.

In addition, we are concerned about development of Aetna's clinical guidelines. It is AMA policy that clinical guidelines must be developed and implemented with the broad-based participation of practitioners and organizations affected. Moreover, under NJAC 8:38-8.1(b), any denial of care must be based on written protocols developed with input from practicing physicians in the network. This does not appear to be happening.

Even before the acquisition of Prudential Healthcare, Aetna's behavior in New Jersey left much to be desired. A Market Conduct Examination by the DOBI documented numerous instances in which Aetna's business conduct did not comply with New Jersey law. Violations encompassed handling of complaints, processing of claims, and advertising. Given this history, the AMA expected to see rigorous implementation of the elements of the consent decree, so we share in the disappointment expressed by MSNJ.

Despite our frustrations with the lack of progress . . . one year after the consent decree went into effect, the AMA—along with MSNJ—appreciates the efforts of DHSS and DOBI to try to improve communication between Aetna and the physician community in New Jersey. MSNJ has indicated that four meetings with Aetna held so far this year have been cordial and have improved communication.

In your capacity as governor, and perhaps more important as a champion of patients, anything you could do to get the process back on track would be deeply appreciated.

Sincerely,  
E. Ratcliffe Anderson, Jr, MD  
Executive Vice President, CEO  
American Medical Association



# Patrick J. Zenner

*President and CEO, Hoffmann-La Roche  
Retiring Chairman, HealthCare  
Institute of New Jersey*



Patrick J. Zenner, who has recently (July 2000) completed a term as chairman of the HealthCare Institute of New Jersey (HINJ), is the president and CEO of Hoffmann-La Roche, a major pharmaceutical company located in New Jersey.

HINJ (pronounced "hinge"), which Mr. Zenner was instrumental in founding, consists of 21 member companies from the pharmaceutical and medical technology industries. Its goal is to promote public awareness of the industry in New Jersey and its importance to our economy, to our state, and to our communities.

In addition to his work with HINJ, he also serves on the board of directors of the Pharmaceutical Research & Manufacturers of America (PhRMA) and of the Biotechnology Industry Organization (BIO).

Mr. Zenner received his bachelor's degree in business administration from Creighton University and holds an MBA from Fairleigh Dickinson University. He now serves on the board of trustees of both of these institutions. He has been with Roche for more than 30 years and has been president and CEO since 1993.

The parent company of Hoffmann-La Roche, Inc., is Roche Holding, Ltd., a Swiss

company. It is one of the 10 largest pharmaceutical companies in the world and is also the world's largest vitamin company and the largest medical diagnostics company. It has a market capitalization of approximately \$100 billion. Roche employs about 4,600 people here in New Jersey and about 3,400 at its campus in Nutley, where we visited Mr. Zenner in his offices.

*New Jersey Medicine* (represented by editorial board members Bernard A.

Rineberg, MD, president of the Academy of Medicine of New Jersey; Patricia A. Costante, senior vice president of The MIIX Group; and Paul J. Hirsch, MD) interviewed Mr. Zenner. We found him to be enthusiastic about the role that the pharmaceutical industry plays in New Jersey, proud of his own company, and knowledgeable about issues facing the medical profession as well as his own industry. [A related article about New Jersey's pharmaceutical industry as well as an editorial appear in this issue.]

**New Jersey Medicine:** Most physicians in New Jersey are unaware of the HealthCare Institute of New Jersey. Can you tell us what its purpose is?

**Mr. Zenner:** The HealthCare Institute was formed in 1997 after years of discussion among industry executives, which came to a head during the health care reform debate during the early 1990s. At that time, the pharmaceutical and medical technology industries were often portrayed as demons and as the cause of increasing health care costs. People did not understand the work that we do, the risks that we take, the value that is created as the result of our products and services. Even our legislators often did not understand our industry.

GOVERNOR WHITMAN HAS  
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ECONOMIC DEVELOPMENT  
AND GROWTH.

The charter members were the major pharmaceutical companies. We wanted the HealthCare Institute to become an authoritative source of information about our industry. We needed to build a sound fact base regarding the value and the importance of the industry and what it means to the state of New Jersey, to the nation, and to the world.

There were several audiences that we wanted to communicate that to. We concentrated first on our elected

officials, since we spent a lot of time with them in Washington and here in New Jersey. In addition, we wanted the public and other health professionals around the state to be better informed about what we do.

We now need to extend our efforts, to reach out to the Medical Society of New Jersey and other health groups, to exchange information, and to find common ground on a number of issues.

**NJM:** Have you achieved success in the short time since HINJ was founded?

**Mr. Zenner:** When we started, we saw this as a building process; we were not looking for an immediate "big bang." But we do feel that we have been successful. We have raised the public awareness of our industry. We emphasized the number of jobs that we create, the value of those jobs, the collateral employment that we create, the investment that we make in research and development, the number of patents and drug approvals that come from companies in New Jersey, and the taxes that we pay.

We created a fact base that demonstrates our economic value to the state. Governor Whitman has



referred to New Jersey as the “medicine chest of the world” and that is a key message. We are demonstrating that our industry is a vital and vibrant part of our state and our state’s economy. We have had the full support of the New Jersey delegation in Congress on important pieces of legislation. Before HINJ existed, with its ability to research and provide data and information, that would have been unlikely.

**NJM:** Has your membership expanded from the original charter members?

**Mr. Zenner:** We expanded our membership to include other pharmaceutical firms and also medical technology firms. The membership has almost doubled over the past three years, to a total of 21 companies.

**NJM:** How does HINJ establish positions that will be acceptable to the diverse companies that constitute your organization?

**Mr. Zenner:** Our basic principals are to preserve free markets, preserve choice in health care, and improve the quality of care. Within the context of those goals there are many individual issues that we can rally around together.

**NJM:** When you say “choice,” what are you specifically referring to?

**Mr. Zenner:** Patient choice. The ability of patients to choose their health plan and their doctor. We hope that is an area in which we can find common ground with MSNJ, although there may be issues that we cannot agree on.

**NJM:** You mentioned the number of jobs created by the pharmaceutical industry in New Jersey. Could you be a little more specific?

**Mr. Zenner:** The companies that make up the HealthCare Institute directly employ nearly 60,000 people. And more than 40,000 people are employed in jobs created in companies that serve our industry.

We also try to emphasize that the type of jobs and the quality of the jobs that we create have tremendous value to the state and our communities. We have a very high percentage of highly educated individuals who try to improve the quality of their communities.

**NJM:** Why is New Jersey such a fertile ground for the pharmaceutical industry?

**Mr. Zenner:** The genesis is historical. Many of the large companies that are based here—including our own, Merck, and Johnson & Johnson—have roots that go back to the 1800s or early 1900s. Some started in New York and then came here. The area offered access to the ports and to regional academic institutions. And so a core base was built, and over time it created an environment that continued to thrive and grow.

Now, because the industry has become concentrated here, it has become additive. We have access to the academic health centers in the tristate region. We have access to a major international airport. And in

recent years, the state has worked more productively with the industry. The atmosphere here is very good.

**NJM:** Is part of this atmosphere a friendly regulatory climate?

**Mr. Zenner:** In the past several years, the state has become a place that has encouraged greater business investment through its policies and its philosophies. That has not always been the case in New Jersey, but in the current administration there has

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MORE THAN \$27 BILLION  
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DOLLARS TO BRING ONE  
PRODUCT OUT.

been a climate that encourages economic development and growth.

**NJM:** One of the criticisms of the pharmaceutical industry is the pricing of medications. Why do prescription drugs cost so much?

**Mr. Zenner:** This is a complex issue. We try to educate various audiences about the investments that we make in research and development and how people should look at the economic context of prices.

Our industry spends more than \$27 billion per year in risk capital on research and development. It takes, on average, 12 to 14 years from the time that we discover a molecule until we bring it to the marketplace. It takes about a half-billion dollars to bring one product out. Only about 6% of what we start with ever makes it to the market. Only about one in three that make it to the market fully recovers the cost of drug development. It is a high-risk business, although it also has potentially high rewards.

Every company must consider its investment in research and development. Our own company spends more than \$2 billion per year globally on research. The time during which this investment can be recovered shortens all the time. In other fields, patent protection extends for 17 to 20 years. In the pharmaceutical industry, we file our patents very early in our research and discovery process. We do have legislation that restores some of that time because of the duration of the regulatory processes, but the average effective patent life of a pharmaceutical product is less than 10 years. We have about half the time that other products would have to recoup our investment. And even that

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INCREASING SHIFT TOWARD  
NONHOSPITAL TREATMENT  
OF MANY CONDITIONS  
AND HELP TO REDUCE  
TOTAL COSTS BY  
DECREASING THE NEED  
FOR HOSPITALIZATION.

time may be shortened by the reduced time it now takes for next-generation drugs to appear.

There is another aspect to this. Prescription medications now account for about 8% to 9% of the health care dollar, a reported rate of increase of 14% to 15% annually. This increase is mistakenly labeled a price increase. There has been a significantly increased utilization of pharmaceutical products in the past few years. It is largely this utilization increase that we are seeing.

**NJM:** Why has this increase occurred?

**Mr. Zenner:** There are several related phenomena. There are new medications and new classes of medications. Better-informed consumers are more likely to seek care. There is improved compliance. And there has been tremendous pressure to shift away from hospital care to outpatient and ambulatory care. We have benefited from several major new classes of drugs for treating several conditions, from arthritis to lipid metabolism. New breakthroughs are offering tremendous relief and improvement to many patients who perhaps were not treated as well previously.

We have more highly educated and better-informed consumers, who have become much more engaged in their own health care. This has been stimulated, in part, by our ability to talk directly to the consumer and by the Internet, where health care is the most widely accessed type of information. Many more patients who have disease who previously were not seeking treatment are now actively going to their physicians and seeking treatment. That, too, causes increased utilization of prescription medicines.



The health care system and our industry have focused more attention on patient compliance. We know, for example, of the long-term benefits of the use of antihypertensive drugs for hypertension. We are working very hard to improve compliance. This also increases the costs of medication, but we believe it reduces overall costs to the system and improves the health of patients.

Finally, better pharmaceutical products allow an increasing shift toward nonhospital treatment of many conditions and help to reduce total costs by decreasing the need for hospitalization.

**NJM:** Pharmaceutical companies are now marketing some prescription medications directly to the public. This may also increase costs by promoting a newer and more expensive medication that is no more effective than older medications. How do you view such advertising?

**Mr. Zenner:** That involves competition and choice. We are all familiar with this process for virtually everything that we buy. We have multiple choices, and we make valuations. In doing that, we use the information that we have.

The companies are providing good and appropriate information. The patient may ask more questions of the physician about a particular product, but in the end the physician must make the final determination. If I were a patient seeing a physician, I would like to be able to discuss what the options are. If I want something that I perceive to be right or better for me, I would want to be able to discuss that with my physician and participate in that decision.

**NJM:** What feedback do you get from physicians when you advertise a product directly to patients? Do they find it helpful, or are they likely to be alienated?

**Mr. Zenner:** Our market research tells us that over the past few years the practicing physician has become much more accustomed to answering questions from patients about medications.

Consumers are demanding information about their own health and health care. Information on the Internet, much of which is junk, is easily available. Patients get information from many sources. And many of those sources will not be as authoritative as the company that discovered and developed the medication. Why shouldn't more authoritative sources and those with the greatest knowledge provide that information directly to consumers?

I think that this is the view of the Food and Drug Administration (FDA), which has liberalized our ability to communicate with consumers. Our industry is stimulating patients who have never been treated to seek treatment, and we are improving compliance. We have an obligation to communicate appropriately, and

then a medical professional must put this in the proper perspective for the individual patient.

If people believe that there is inappropriate prescribing because of this, I would go back to the medical profession and say, "You can say no."

**NJM:** There has been concern about the funding of clinical research by the pharmaceutical industry and the potential for this funding to influence researchers. Clearly, what you want is the most

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objective study possible. How do you protect yourself against any such bias in those doing research?

**Mr. Zenner:** It is in our interest, and in everyone's, to maintain the integrity of the process and the system. I take offense when some say that physicians who engage in doing work for the industry are biased.

We need to work with medical professionals who are expert at what they do. Physicians will see through it if we are not doing credible work or if we do not have credible medical data. We cannot stay in business if we do not produce the highest quality clinical research. Good science means good medicine and good business.

**NJM:** How do you protect yourself from faulty clinical research?

**Mr. Zenner:** At Roche, we perform due diligence to select physicians who are competent and who have a track record of performing proper investigations. We audit all of our clinical trials, and we have a network of medical monitors who investigate the investigators to determine whether they have the capacity and the capability to perform clinical trials. We go to great pains to ensure our process.

Also, the institutions to which most of these people are attached go through their own processes as well. Although the system generally works well, we must continue to strengthen our self-policing mechanisms. It is incumbent on both sides to preserve the independence and integrity of the clinician.

**NJM:** Is the type of system that you have outlined, including a due-diligence process in selection of clinical investigators and an internal auditing process,

PROTECTION OF THE  
SUBJECTS IN CLINICAL  
TRIALS IS A VERY  
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PROTOCOLS OF EVERY  
PHARMACEUTICAL  
COMPANY.

standard among the major pharmaceutical companies?

**Mr. Zenner:** Yes, I believe that it is.

**NJM:** How do you ensure the rights and the safety of the patients in your clinical trials?

**Mr. Zenner:** Protection of the subjects in clinical trials is a very important part of the protocols of every pharmaceutical company.

Those must be observed. We follow it

closely, monitor it, and we audit very carefully to make sure that every investigator follows the protocols that have been set.

**NJM:** Physicians in small clinical practices sometimes want to participate in clinical trials without understanding the infrastructure that they must develop for these activities. Do you see this as a feasible activity for smaller practices?

**Mr. Zenner:** I would be skeptical. We know how difficult it is, even in a well-organized institution, to follow all the details and do it well. It would be extremely hard for small practices to do this. But if they can organize themselves, some will be able to.

I find that many health systems are also attempting to better organize themselves to compete for that business. They are trying to learn what it would take, and we try to help educate them. In the final analysis, we would not work with anyone unless they prove to us that they can do it, because if they fail, we fail. If the clinical research is not done well, it leads to bad data, lost money, and lost time.

**NJM:** Do you believe that there will be more general population trials done?

**Mr. Zenner:** Perhaps. There may be trials that are not part of the support of a new drug application, but



rather studies in which the manufacturer is looking to obtain a better understanding of a drug in real clinical practice. This might be an area in which there could be a role for some physician practices.

**NJM:** At your company, do you do your own clinical research, or do you also use contract research organizations (CROs)?

**Mr. Zenner:** We do use CROs. I would guess that about 25% to 30% of clinical research in the industry today is done by CROs. I personally do not expect that to grow much. Like the movement to outsource many other things in industry, it is not a magic answer to providing higher quality, lower cost, or better productivity and efficiency. In fact, there may be a loss of certain aspects of business control that are important. In this situation, that includes direct interaction with those who are investigating your product.

On some occasions, however, we may feel that a CRO can help us during certain periods and in some circumstances. But, I do not see CROs replacing our internal processes.

**NJM:** Has the HealthCare Institute taken a position regarding proposed programs to provide prescription medications for the elderly?

**Mr. Zenner:** The HealthCare Institute of New Jersey supports the positions of PhRMA, which is our major trade association, and an organization called Citizens for Better Medicare. Those positions state that prescription medications should be made accessible to all citizens.

The HealthCare Institute believes that there must be modernization of

the entire Medicare program and that prescription medicines should be part of a modernized program. However, we understand that modernizing the entire program may not be politically feasible in the short run. An interim solution is necessary.

We do have differences with some current proposals with regard to how they are administered. Our view is that senior citizens should have access to prescription medicines through a choice of private health care plans. There should be subsidies, determined by Congress, for those who are unable to pay. Others should pay premiums but should be able to choose among competing health plans for their prescription drug coverage as well as for their overall coverage. We are opposed to a one-size-fits-all solution of a single program that would be administered by the federal government. Our fear is that that type of program would bring direct or indirect price controls. We believe that choice would be restricted and quality would be affected.

**NJM:** Do you believe there will be increasing federal regulation of your industry over the next few years?

**Mr. Zenner:** That depends in part on the new president and the new Congress. There are a number of issues in health care that need to be addressed and that hold the potential for new laws and new regulations. The issue of privacy in health care has not been fully resolved. The issues that derive from genetics and genomics have yet to be fully elucidated and fully debated. And there is likelihood that there will be regulation in those areas. The uninsured

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population in this country is still a major issue that we have not resolved. Adding prescription medicines to our senior population's benefit package offers the potential for more laws.

In sum, then, we are likely to see more legislation and regulation as our country tries to resolve these issues.

**NJM:** One of the issues that the medical community has struggled with in the past few years has been the emphasis on fraud legislation. There recently has been an emphasis on the for-profit hospital chains. Now that emphasis seems to be shifting to the pharmaceutical industry and its pricing patterns. Is that something that the HealthCare Institute will be involved in?

**Mr. Zenner:** It is hard for an association to deal with or talk about pricing, and specific pharmaceutical pricing practices would be off limits for our organization. We have not taken a position, because the investigations that have occurred have involved specific companies and specific issues.

In one recent reported issue, an investigation has apparently uncovered instances of artificially high published wholesale cost of medication, which is then sold at a discount, allowing a higher reimbursement rate. There were other claims several years ago in which groups of companies were accused of trying to maintain prices in several therapeutic categories. These are investigated, and a conclusion reached. HINJ can have no position on these individual cases.

Our view is that we believe in competitive markets and competitive pricing and freedom of choice.

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The government has looked at potential or possible fraud and abuse in virtually every area of health care, including doctors, labs, hospitals, and pharmaceutical companies. Everyone has come under their microscope and has been affected. I believe that the complexity of regulations and laws have created a lot of the difficulty. People are not neces-

sarily deliberately trying to disobey the law. The Medicare regulations are, I think, about 135,000 pages long. How can any single person or entity fully understand that? And the regulations are interpreted in many different ways. It is a real problem.

**NJM:** We are struck by the fact that you have been with the same company for more than 30 years. Isn't that a little unusual?

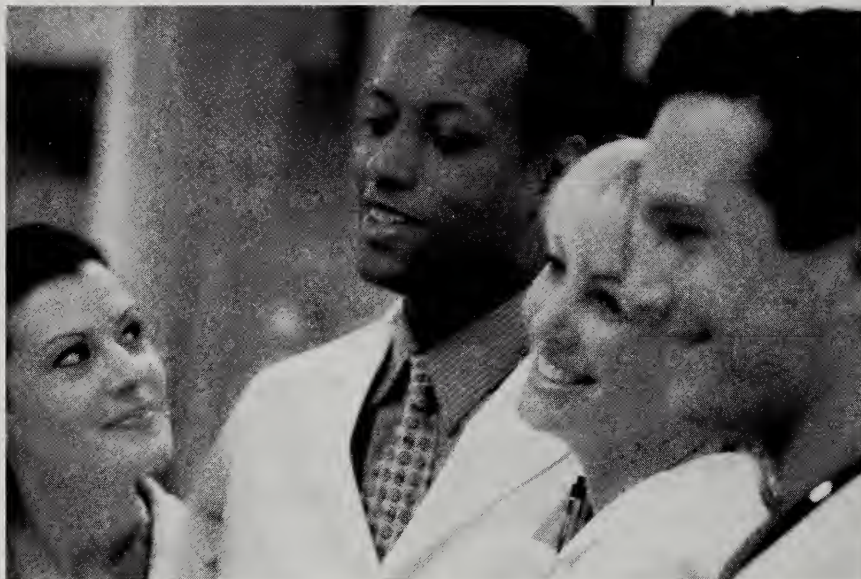
**Mr. Zenner:** I have always felt very fortunate to be at Roche. I appreciate its values, its standards, and the opportunities that it has given me. Although we are publicly traded, we are still a family-held company. The majority of the voting shares are held by descendants of the Hoffmann family. They have been extremely supportive of innovation and research and development and also very supportive of management. It has created a special atmosphere for me.

We have a lot of very dedicated people. I tell our new people that they should feel privileged to work for this company and in this industry. Our work is important in improving the health and well-being of people. That brings a special feeling and obligation. We find it very rewarding when we hear about the value that our products have brought to doctors and patients.

**NJM:** Mr. Zenner, thank you for your time and frank discussion.



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# Legislative Process Thoroughly Tested in HMO Repayment Plan

*Assemblyman Christopher "Kip" Bateman*

Managed health care insurance remains a prime area of interest to New Jersey residents. As a member of the New Jersey General Assembly and in my role as chairman of its banking and insurance committee, I am often called on to explain our work in this area. In crafting workable policy, the viewpoints of health care insurance policyholders, primary care physicians, and health care providers must be equally considered. It is only after we listen to these many voices, each with legitimate concerns, that legislation is crafted and public policy served.

The health needs of the clients must be served and accommodated but also must be weighed against the costs to the providers. A balance must be established if health care premiums are to remain affordable to those seeking such services.

It is almost certain that no matter what course of action is decided on,

some party may believe itself disadvantaged.

When I agreed to sponsor Assembly Bill 1890, the New Jersey Insolvent Health Maintenance Organization (HMO) Assistance Fund Act of 2000, I had to ponder what should be included in the bill to make it as fair as possible to as many of the interested parties as possible. In addition, I had to consider how would it be implemented. The solution and resulting legislation would require reaching a supportable consensus among many often-opposing viewpoints.

The need for this legislation can be traced back to 1997 when, in an attempt to rejuvenate the financially troubled Health Insurance Plan of New Jersey, Inc. (HIP-NJ), the Departments of Banking and Insurance (DOBI), Health and Senior Services (DHSS), and Law and Public Safety approved the sale of the HMO health care centers and physicians' networks to Pinnacle Health Care Corp., which would

operate as a third-party administrator. At the time, current law did not permit the state to review the financial condition of a third-party administrator, which is an entity that provides certain services for managed care organizations. There simply was no state law at the time that called for ensuring that third-party administrators were capable of meeting financial and health care delivery requirements.

While the collapse of HIP-NJ can be attributed to many factors, in hindsight financial experts suggested that the actions that occurred could have been averted if the state had possessed the statutory or regulatory authority to perform in-depth examinations of the financial records of both HIP-NJ's former partner, Pinnacle Health Enterprises, and its parent company, PHP Health Care Corporation.

However, DOBI was precluded from requiring either company to maintain a cash reserve to ensure continued care of HIP-NJ members. While



## Legislative Report

DOBI and DHSS share dual authority for the timely regulation of HMOs, the departments did not have adequate statutory control over these organizations to require certain actions that may have helped to ensure their continued ability to function.

DOBI is responsible for the initial and ongoing financial review of such entities, while DHSS is responsible for the issuance of certificates of authority to operate an HMO in New Jersey. It also is responsible for monitoring the industry.

In the spring of 1999, DOBI adopted regulations giving it greater control in areas where deficiencies had been noted. These regulations tightened certification requirements, increased auditing procedures, and established specific asset and financial standards.

As required by law, the state issued an order of special open enrollment (Order No. 99-108) to provide stranded clients an opportunity to select another health care provider.

Clients enrolled in new health care plans but were able to continue their course of treatment with their current physician for a limited time; the order also provided that prescriptions for certain maintenance drugs would continue for another 30 days. Physicians and hospitals

were prohibited from billing HIP-NJ clients for covered services other than normal copays and deductibles.

In response to the bankruptcy of HIP-NJ and the American Preferred Provider Plan, Inc. (APPP), the legislature recently enacted PL1999, c.109 to permit DOBI to certify all risk-assuming organized delivery systems. Such entities would be subject to insurance law and financial examinations similar to licensed insurers. In addition, the act requires an organization to maintain a minimum net worth commensurate to its size and exposure to financial risk. As with licensed insurers, the delivery systems would be required to deposit cash, securities, or other approved instruments with the state. All assets and income would be available to the state in the event of the organization's insolvency.

My legislation, A-1890, created an insolvency trust fund to repay doctors and hospitals \$100 million of the \$150 million owed to them for the good-faith services they provided clients. Of that amount, \$50 million would come from the state, through its share of the tobacco industry settlement proceeds, and \$50 million would be assessed to the HMOs doing business in New Jersey over the course of the next three years. The HMO assessment would

be based on each company's net written premiums received on HMO business in New Jersey.

The monies would be awarded only to those doctors and hospitals that agreed to forgive one-third of the contractual obligations owed to them.

During the public hearings, we heard arguments from the doctors and the hospitals that supported the policy as well as from the HMOs, which adamantly opposed it.

After hearing all compelling testimony from all the parties, this unprecedented, commonsense legislation was truly a fair compromise. The companies can absorb the costs assessed to HMOs without affecting the rate structure to current or future New Jersey clients.

The sad cases of HIP and APPP showed that a strong but fair regulatory policy must be in effect to protect the health care interest of the public and the providers themselves. The legislative process in this matter once again showed that not every piece of public policy will be favorably supported by each interested party. In the interest of fairness and serving the greater need, the legislation passed and was signed into law on April 6.

*Kip Bateman is an assemblyman from the 16th legislative district and chairman of the Banking and Insurance Committee.*

# The Diabetes and Obesity Epidemic Among the Pima Indians

THE PIMA INDIANS ARE THE FATTEST POPULATION GROUP IN THE FATTEST COUNTRY ON EARTH,<sup>1</sup> AND THEY HAVE THE HIGHEST PREVALENCE OF DIABETES IN THE WORLD. DESPITE UNPRECEDENTED RESEARCH BY THE NATIONAL INSTITUTE OF ARTHRITIS, DIABETES AND DIGESTIVE AND KIDNEY DISEASES (NIH) AND GOOD CARE BY THE INDIAN HEALTH SERVICE (IHS), THE PROBLEMS HAVE GROWN WORSE SINCE FIRST RECOGNIZED IN 1963. THE CAUSES ARE MULTIPLE: ENVIRONMENTAL, GENETIC, CULTURAL, AND PSYCHOSOCIAL. THE REAL VILLIAN, HOWEVER, IS THE DISEASE, DIABETES. THE SOLUTION IS PREVENTION IN PIMA CHILDREN.

*Arthur Krosnick, MD*

**T**he Pima Indian tribe, of about 11,000 people, lives in the Sonoran Desert on the Gila River Reservation in Arizona; they have lived in that region for at least 2,000 years. For millennia, these River People survived and flourished. They developed an irrigation system, which made it possible to grow wheat, beans, squash, and cotton. The Pima men were strong runners, farmers, fishers, and hunters, while

the women were homemakers, gatherers of food, and master weavers.<sup>2</sup>

Today, the lean and muscular men and trim women and children of the Pima tribe of yesteryear have largely been replaced by a population with the highest prevalence of type 2 diabetes in the world. [Type 2 diabetes usually occurs after age 30 in persons who are obese and have a positive family history of diabetes. Its unique pathophysiology includes hyperglycemia, insulin resistance,

hyperinsulinemia, impaired  $\beta$ -cell function, increased hepatic glucose output, and impaired glucose disposal, primarily in muscle and in other peripheral tissues. Type 2 diabetes is more prevalent in ethnic minorities; minority children as young as 10 years old may have it.] Sixty percent (600 persons per 1,000 population) of the age group 34 to 64 are diabetic. The rate of diabetic nephropathy (end-stage renal disease) is more than 20 times



that of the general population. The reservation's dialysis unit treats 18 patients at a time every 14-hour day, six days a week. In addition, Pimas have excessive rates of serious diabetic retinopathy, leg amputations, hypertension, and cardiovascular mortality related to chronic hyperglycemia.<sup>1,3</sup>

### Environmental and Genetic Factors

When and why did the Pimas, who separated from their Mexican relatives and migrated north to what is now Arizona, become obese? Their usual diet had been about 15% fat and was high in starch and fiber. The "westward-ho" farmers, north of the River People, diverted the upper Gila River during the late 19th century. The Pima life of hunting, gathering food, fishing, and later agriculture was vastly changed. Alternate periods of feast or famine and prolonged drought resulted in impoverishment and undernourishment.

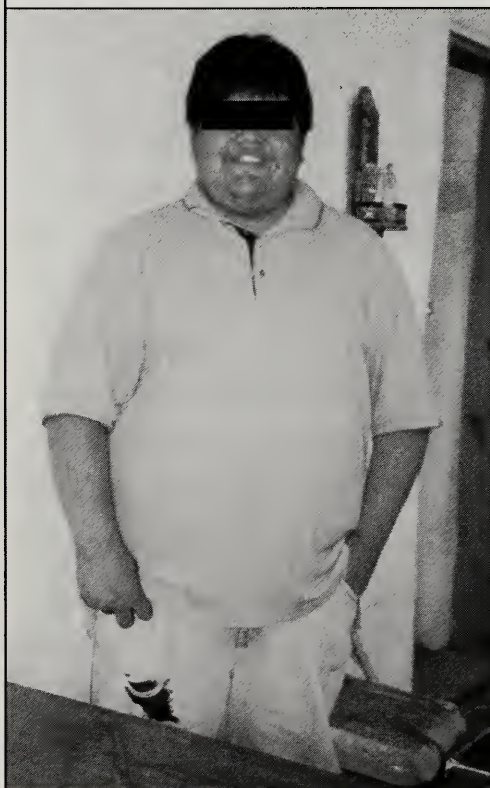
The situation drastically changed again during the Depression and World War II, when Native Americans joined the armed forces or found urban factory employment. At that time, the US government distributed commodity foods to poverty-stricken persons, including American Indians. Those nutrients consisted of sugar, white flour, cheese, and lard. The result

was a change from traditional Pima eating habits to a high-fat diet, which provided 40% of their daily caloric intake from fat. Their staple food changed from corn tortillas to fry bread, which is a white flour loaf cooked in boiling lard. Not surprisingly, weight gain led to obesity, which ultimately reached morbid proportions.

In 1963, visiting scientists from the National Institute of Arthritis, Diabetes and Digestive and Kidney Diseases (NIDDK) selected the Pima tribe to study the prevalence of rheumatoid arthritis. Instead, they made a serendipitous discovery that 50% of the adult Pimas had morbid obesity and type 2 diabetes.

J. V. Neel, a geneticist, studied the Pima population and proposed a

*The modern Pima Indian lifestyle includes a high-fat diet and limited physical activity.*



thrifty-gene hypothesis. This interesting but unproved concept postulates that Pimas survived in periods of famine by storing fat during times of plenty. This genetic mutation, if real, may have occurred over a period of hundreds or thousands of years.<sup>2</sup>

Could this hypothetical genetic mutation be akin to a similar event, which may have occurred one to two million years ago? At that period, Africa was drying and soft fruit and vegetables were scarce. Recent studies of the bones of a chimpanzee-like male hominid, *A. robustus*, were made. Archaeologists found that this humanlike mammal developed "large jaws and molars to handle . . . tough foods like roots, tubers, and seeds." Their explanation was that difficulty competing for food with hyenas, saber-toothed cats, and leopards caused them to subsist on "tough foods" to survive.<sup>4</sup>

Another visiting scientist, Eric Ravussin, studied obesity in the Pimas in 1984 and agreed that the thrifty-gene theory may be applied to this group of Native Americans. Thus, the thrifty gene that once protected people from starvation might also contribute to their retaining unhealthy amounts of fat.<sup>2</sup> Conclusions of recent genomic research by Hanson et al. stated "Genetic factors influence the development of type 2 diabetes mel-

litus, but genetic loci for the most common forms of diabetes have not been identified."<sup>4</sup> However, in an extensive review article, Arye Lev-Ran questions a simple answer for Pimas. He states that:

Neel's modified hypothesis [1998] is more likely, i.e. that obesity, diabetes, and hypertension reflect genetically complex, homeostatic systems that . . . may be called "civilization syndromes or altered-lifestyle syndromes."<sup>5</sup>

Recent research has added another concept. Fox et al. studied 224 Mexican Pima Indians and 418 US Pima Indians. They measured "plasma leptin, an important signal for the regulation of energy stores," to study the impact of diet composition and physical exercise among Pima Indians living in entirely different environments. Leptin values were strongly correlated with the percentage of body fat in both groups. The lean, nondiabetic Mexican Pimas, who weigh 60 pounds less than their Arizona kin, had higher leptin values. The obese Arizona Pimas with type 2 diabetes had lower leptin values than nondiabetic subjects. The researchers concluded that "leptin concentration may be increased by environmental factors, such as a high-carbohydrate diet and a high level of physical activity" (Mexican Pimas).



*The Pimas are worse off than they were 20 to 30 years ago.*

This may explain the low leptin values in US Pimas, whose lifestyle includes a high-fat diet and limited physical activity.<sup>5</sup>

### Diabetic Factors in Children and Adults

So, why did the Pimas develop type 2 diabetes? It is common knowledge that obesity and diabetes are closely linked. The Pima Indians, a closed society, bore children over millennia within their own native people. Could there have been a genetic mutation favoring the development of diabetes? Can hyperglycemia be "protective" during periods of starvation, and could a relatively rare diabetes gene have been passed along to larger pools of Pima offspring over hundreds or thousands of years? Could the obesity of thrifty-gene origin have part-

nered with a diabetogenic gene to cause the epidemic? It could have, but recent scientific evidence has shed new light on the question.

### An Epidemic of Type 2 Diabetes in Children

It is well-known that exposure of the fetus of a diabetic mother to hyperglycemia is toxic; the child has three times more likelihood of birth defects, large birth weight (more than 9 pounds), premature delivery, and respiratory, brain, and neuro-pathic problems. Offspring of non-diabetic or normoglycemic diabetic mothers do not experience those problems. Recent animal studies and research in pregnant diabetic Pima mothers showed that exposure of their offspring to the toxic diabetic intrauterine milieu can increase their risk of developing diabetes and obesity earlier in life. This nongenetic risk is an add-on to the genetic predisposition of a child of a diabetic mother.<sup>2</sup>

It has also been recognized, over the past few years, that type 2 diabetes in children age 10 years and older has developed among the ethnic minority groups in families with high rates of adult diabetes. These include Americans of Native, Hispanic, African, Asian, and Asian Indian descent. Type 2 diabetes has been considered rare in children, but data increasingly suggests that a



diabetes epidemic has developed. Dabelea et al. studied 5,274 Pima Indian children between 1967 and 1996 in three 10-year time periods, for ages 5 to 9, 10 to 14, and 15 to 19 (see Table 1).<sup>7</sup>

Type 2 diabetes, now a common disease in American Indian children older than 10 years, is associated with increasing weight gain to morbid levels. In the table, the prevalence of type 2 diabetes in Pima girls exceeded that of boys in both age groups and in both decades. As stated, present evidence suggests that increasing fetal exposure to hyperglycemia in the uterus of a diabetic mother may be the major cause of this problem.<sup>2</sup>

**Cardiovascular Mortality  
in Adults**

Sievers et al. studied the effect of glycemia on mortality in 1,745 adult subjects. They concluded that "In Pima Indians with type 2 diabetes, higher plasma glucose concentration predicts deaths from cardiovascular disease and diabetes-related diseases but has little or no effect on deaths from other natural or external causes." Of 533 subjects followed for more than 10 years, 113 died of cardiovascular disease. The authors found that an increase of 100 mg/dl (5.6 mmol/l) at the two-hour plasma glucose level was associated with a 1.2 times increase in the death rate from cardiovascular disease.<sup>3</sup>

**Bioethical Issues**

The Phoenix Epidemiology and Clinical Research Branch of the National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health in Arizona, under the direction of Dr. Peter Bennett, has been doing outstanding research on Pima Indian subjects since 1963. Dr. Bennett stated: "The Pima Indians are giving a great gift to the world by continuing to volunteer for research studies. Their generosity contributes to bet-

SIXTY PERCENT OF PIMA INDIANS IN THE AGE GROUP 34 TO 64 ARE DIABETIC, AND THE RATE OF DIABETIC NEPHROPATHY IS MORE THAN 20 TIMES THAT OF THE GENERAL POPULATION, WITH EXCESSIVE RATES OF SERIOUS DIABETIC RETINOPATHY, LEG AMPUTATIONS, HYPERTENSION, AND CARDIOVASCULAR MORTALITY RELATED TO CHRONIC HYPERGLYCEMIA.

ter health for all people, and we are all in their debt." Dr. William Knowler at the Phoenix branch said, "Our greatest pride is in conducting research that affects clinical practice."<sup>2</sup>

Indeed, Bennett and his associates have much to be proud of. For nearly four decades, they have conducted the most intensive and extensive continuous high-quality scientific investigations on a single homogeneous population, in a localized enclave, in our nation's history. They have uncovered priceless epidemiological, genetic, basic research, and clinical data that should be translated for the benefit of the Pimas and for all persons with or at risk for type 2 diabetes. This especially applies to minority ethnic groups in the United States.

Despite the accumulation of all this well-published new information, the Pimas are worse off than they were two to three decades ago. Is there an explanation for that paradoxical condition? Was there insufficient translation of the NIH research data to clinical endocrinologists, primary care physicians, certified diabetes educators, and tribal staff who deal with persons with diabetes?

The IHS is responsible for providing federal health services to American Indians and Alaska Natives based on a federal govern-

ment and Indian tribal relationship that was established in 1787 and confirmed by many treaties, laws, Supreme Court decisions and executive orders. As the principal health care provider and health advocate for approximately 1.5 million Indian people in more than 550 federally recognized tribes, the IHS mission is "to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level." From my observations, the IHS National Diabetes Program, with headquarters in Albuquerque NM, has a very competent and dedicated staff.<sup>8</sup>

This author has met with IHS national staff members and with physicians, nurses, and other health professionals and their patients at tribal health centers at several pueblos in New Mexico over the past three years. They have attempted to provide the best care and education to their diabetic patients, despite funding and bureaucratic limitations and patient noncompliance. One can identify with the frustrations that come with the territory.<sup>8</sup>

As to clinical diabetes research in Indians other than Pimas, very few are included in pharmacological protocols. A study (in which this author is a participant) evaluated the effect of an oral hypoglycemic agent, with or without insulin, in children from 9 to 15 years of age with type 2

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WHITE FLOUR, CHEESE,  
AND LARD.

diabetes. The protocol was looked on favorably by the IHS institutional review board chair. Nationally, study participants were virtually all Hispanic and African Americans. Not a single Native American child was enrolled in the study. Physicians at three pueblos in New Mexico were interested in participating but were unable to get permission from tribal governing leaders. We were unable to learn their reasons.

### Psychosocial Factors

Invading Spaniards discovered the Pimas in the 17th century, at a time when survival activities occupied them most. To the Spanish—whether soldiers, ranchers, or missionaries—they were both serfs to exploit and

souls to convert. According to the *repartimiento* system, the Indians owed the Spanish taxes in the form of labor, crops, and woven goods.<sup>9</sup> Land grants to white settlers, intertribal warfare, and anti-Indian federal policies led to many other negative environmental and social factors. Language barriers and cultural and religious beliefs made social relationships troublesome.

Today, improved legal rights, ownership of land, free health care, and free education have improved their lives. The Pimas own a gambling casino, which provides money to help them move toward mainstream America. It is understandable, however, that Native American feelings of suspicion toward Anglo-Americans linger, in view of their past history of abuse. An example is the Indian mother who ran to the health clinic when her son told her that the nurse said that his blood test showed that he had diabetes. The mother screamed at the nurse for putting a curse on her son and causing him to develop diabetes.

### Is There a Solution to the Pima Indian Dilemma?

Why have NIH research and IHS education, health care, and preventive services failed to reverse, delay, or halt the rapid progression of obesity and type 2 diabetes? Should the development of morbid and deadly



complications have been prevented? Were important research findings not translated into clinical programs quickly enough for primary care physicians? The probable answer to the progressive worsening of the obesity and diabetic complications in the Pima Indians between 1963 and 1999 is multifactorial. The major offender is the diabetes itself and its complex genetics. Delayed diagnosis of this silent disorder gives time for complications to arise in the eyes, kidneys, nerves, and heart. Unfortunately, 10, 20, or 30 years of delay in diagnosis and failure to intensively treat hyperglycemia leads to a point of no return.

In 1963, public health case-finding studies were just beginning, but children were excluded. There was little or no education available for diabetes patients, the public, or health professionals. The concept of patient self-management was not known, while diet instruction got short shrift from both doctors and diabetics. Animal insulin had been available for 40 years, but most physicians were not highly skilled in its use. The importance of "tight glucose control" had not caught on. The first sulfonylurea drugs became available in 1955, but there were no glucose monitors, hemoglobin A1c tests, laser treatment, or early tests for nephropathy. There was little

knowledge of diabetic wound healing, and too often amputation was the first resort. Antibiotics were just becoming available for prescription by physician. Doctors had no organized system of patient education and patients were noncompliant with insulin, antidiabetic tablets, diet control, and exercise."

When NIH scientists discovered that 50% of the Pimas were grossly obese and diabetic in 1963, many of them had already reached the point of no return. The degenerative process was progressive and neither

CAN HYPERGLYCEMIA BE  
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EPIDEMIC?

reversible nor stoppable. Coupled with their disbelief, suspicion, a sense of inevitability, and limited education, noncompliance was probably inevitable.

An IHS physician related the following anecdote to the author. After completing his family practice residency, he was initially assigned to the Santa Fe Indian Hospital to work in the diabetes clinic. After performing a thorough history, physical examination, and laboratory tests on one of his first patients, he bluntly informed his patient, a Navajo Indian male, of his findings and recommendations. The doctor told his patient that his out-of-control diabetes had damaged his eyes, kidneys, and nerves. He recommended weight loss, daily insulin injections, and an exercise program. The Indian listened but asked no questions. He silently stood, turned, and walked out the door, without speaking a word. He never returned for another visit. The physician was bewildered. Professor Edward T. Hall, a brilliant cultural anthropologist who lived with the Indians as a youth, explained it this way:

The Navajo greeting does not center on showing relative strength and dominance . . . but is instead a communication in which there is a mutual assessment of feelings and expression. As two men

approach each other, eye contact is broken . . . they look past each other. . . . To look directly at the other is tantamount to swearing at them. . . . When each has both sent and received the warmth and pleasure of meeting, as well as a sampling of each other's underlying mood, then they have in a subtle way also communicated mutual respect.<sup>11</sup>

In this case, a misunderstanding or misreading of each other's culture can be deadly.

### What Can Be Done Now?

An initial goal should be to encourage all Pimas to undergo screening for undiagnosed diabetes and impaired glucose tolerance. Although some such studies may already have been done, a major continuing emphasis must be placed on the high-risk children: age 10 and older, overweight or obese, with a positive family history of diabetes and possibly with acanthosis nigricans. They and their family members should be tested and educated and reeducated about diet, good health practices, and exercise. They need careful and continuous preventive treatment, before and after diabetes is diagnosed, to avoid the point at which diabetic retinopathy,

## PRESENT EVIDENCE SUGGESTS THAT INCREASING FETAL EXPOSURE TO HYPERGLYCEMIA IN THE UTERUS OF A DIABETIC MOTHER MAY BE THE MAJOR CAUSE OF TYPE 2 DIABETES IN CHILDREN.

nephropathy, and neuropathy are progressive.

The solution to the diabetes and obesity dilemma should start with the children, as well as their family members and their health providers. A maximal sustained effort by all parties is the key to the survival of the Pima Indian tribe and all high-risk minority populations.

*Arthur Krosnick is medical director of AMP Diabetes and Education Consultants in Princeton and clinical associate professor at Robert Wood Johnson Medical School, Piscataway.*

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# The New Jersey Youth Tobacco Survey:

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## Implications for Policies, Programs, and Clinical Practice

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*Cristine D. Delnevo, PhD, MPH; Dawn M. Berney, MPA; Allison S. Gertel, BS; Shyamala Muthurajah, MBBS; Susan Lenox Goldman, MA; Cynthia Kirchner, MPH*

**T**obacco use is the single most preventable cause of death and disease.<sup>1</sup> At the same time, youth constitute an alarmingly disproportionate share of all new smokers (90%). Furthermore, more than 80% of current adult tobacco users started smoking cigarettes before the age of 18.<sup>2</sup> The significance of this has been noted by David Kessler, former commissioner of the Food and Drug Administration (FDA), who classified smoking as a "pediatric disease."<sup>3</sup> Clearly, because youth are a critical target population for the manufacturers of tobacco products, they also must be one of the critical target populations for tobacco control strategists.

While the Master Settlement Agreement (MSA) resulted in changes to the laws that govern tobacco company business practices

(e.g., the removal of cigarette billboards), such changes are necessary but not sufficient for a meaningful impact on tobacco use in New Jersey. To bring about a notable reduction in the number of New Jerseyans who smoke, the New Jersey Department of Health and Senior Services (DHSS) is implementing a sustained, comprehensive tobacco control program to decrease the disability, disease, and death associated with the use of tobacco among New Jerseyans. The primary goals of the program include:

- Decreasing the acceptability of tobacco use.
- Decreasing youth initiation of tobacco products.
- Increasing the initiation of tobacco dependence treatment (cessation) among all tobacco users, including youth.

- Reducing exposure to environmental tobacco smoke (second-hand smoke).
- Reducing disparities related to tobacco use among different population groups.<sup>4</sup>

Surveillance and evaluation are integral to successful tobacco control programming.<sup>5</sup> Accurate baseline surveillance data will allow DHSS to determine New Jerseyans' knowledge and attitudes about tobacco and tobacco practices before the implementation of a comprehensive tobacco control program. Given the high priority placed on youth tobacco prevention, DHSS initiated a New Jersey Youth Tobacco Survey (NJYTS) to provide comprehensive baseline and trend data on the attitudes, knowledge, and behaviors of middle and high school students in the state. The information obtained from the



NJYTS will guide the design, implementation, and evaluation of a youth-targeted tobacco control program. This article summarizes key findings from the first NJYTS and places the results in the context of the goals of the New Jersey Comprehensive Tobacco Control Program.

## Methodology

**Sample.** The target population for this study was 7th to 12th grade students in New Jersey public, private, and charter schools. A two-stage cluster sample design was used to assess both statewide and regional trends. The first-stage sampling frame was constructed from all public, private, charter, and vocational middle and high schools in New Jersey and included 1,766 schools. The sampling frame was stratified by school classification (i.e., high school or middle school) and five geographical planning regions. Approximately 20 schools were selected with a probability proportional to size (PPS), without replacement, from each school classification region for a total of 99 high schools and 102 middle schools. The second stage of sampling involved the random selection of classes within the sampled schools. The second-stage sampling was designed to yield approximately 120 students per school.

**Instrument.** Students were surveyed using the New Jersey Youth

Tobacco Survey (NJYTS) instrument. The instrument was designed to meet specific needs of the New Jersey Comprehensive Tobacco Control Program and was based on existing instruments: CDC Youth Tobacco Survey,<sup>6</sup> National Youth Tobacco Survey,<sup>7</sup> and the California Independent Evaluation High School Tobacco Survey.<sup>8</sup> The instrument was self-administered and used a scannable questionnaire booklet. The NJYTS addressed eight content areas: tobacco prevalence, access to tobacco products, smoking cessation, smoking intention, perceived consequences of tobacco use, mass media, awareness of tobacco industry strategies, and environmental tobacco smoke.

**Survey Administration.** Selected schools were contacted to solicit

their participation; 164 schools agreed to participate. An overall participation rate of 71% was achieved; overall participation rates are calculated by multiplying the school participation rate by the student participation rate. The survey was administered to 8,798 middle school students (grades 7-8) in 84 schools and 7,318 high school students (grades 9-12) in 80 high schools located throughout New Jersey.

**Analysis.** The data was weighted to adjust for nonresponse at the grade, school, and regional level, providing results that are representative of New Jersey's 7th to 12th grade student population. Survey data was analyzed using SPSS for Windows; variance estimates and 95% confidence intervals were calculated using SUDAAN.

## Results

### Prevalence of Tobacco Use among New Jersey Middle School Students.

The NJYTS assessed current tobacco use for several tobacco products; current tobacco use is defined as using tobacco on one or more of the 30 days preceding the survey (see Table 1). Approximately one in five (18.9%) middle school students are current users of *any* tobacco products (cigarettes, cigars, bidis [i.e., small, brown, hand-rolled cigarettes primarily made in India and other southeast Asian countries], or smokeless tobacco). Cigarettes are the most commonly

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used tobacco product (10.5%). However, middle school students also report significant use of other tobacco products such as cigars (9.3%), bidis (7.9%), and smokeless tobacco (SLT) (4.3%) in the 30 days preceding the survey.

Gender differences exist for cigar and smokeless tobacco use, with male students having significantly higher use rates than females. Several significant racial and ethnic differences were also detected. Among middle school students, African-American and Hispanic students report significantly higher rates of use of any tobacco and bidis than white students. In addition, African-American students were more likely to report smokeless tobacco use than white students.

### Prevalence of Tobacco Use among New Jersey High School Students.

More than a third (38.9%) of high school students are current users of any tobacco products (cigarettes, smokeless, cigars, or bidis). Cigarettes are the most commonly used tobacco product (27.6%), followed by cigars (18.4%), bidis (14.1%), and smokeless tobacco (10.7%) in the 30 days preceding the survey (see Table 2).

Similar gender differences exist among high school students, with male students having significantly higher use rates for cigars and smokeless tobacco than females. However, different racial and ethnic differences were detected for high

## APPROXIMATELY ONE IN FIVE (18.9%) MIDDLE SCHOOL STUDENTS ARE CURRENT USERS OF ANY TOBACCO PRODUCTS (CIGARETTES, CIGARS, BIDIS, OR SMOKELESS TOBACCO).

schools students than for middle school students. African-American students had a significantly *lower* prevalence of current cigarette use than white or Hispanic students. Furthermore, the racial and ethnic differences detected among middle school students (i.e., bidis and smokeless tobacco) were *not* found among the high school students.

### Tobacco Prevalence by School Grade.

As detailed in Figure 1, the proportion of students currently using tobacco products increased notably by grade. A significant increase is noted between 7th and 8th grade, where cigarette use increased by 128% and bidi use increased by 39%. The largest increase for cigar and smokeless tobacco use occurred between 8th and 9th grade, at 49% and 112% respectively.

### Brand Use by Race/Ethnicity.

Among students who smoked cigarettes in the 30 days preceding

the survey, the most common usual brand was Newport (43.5%), followed by Marlboro (30.8%). Other usual brands were Camel (4.8%) and Virginia Slims (1.8%); 9.7% reported that they had no usual brand. This trend held for gender and school type (middle school versus high school). However, as detailed in Table 3, usual brand differed substantially by race. Newport is the most common brand among African-American (71.7%) and Hispanic (62.2%) students, while Marlboro is the most common brand among white students (40.7%).

**Exposure to Environmental Tobacco Smoke.** Almost half (44%) of the students report that they live with someone who smokes cigarettes. Students were asked on how many days in the seven days preceding the survey they were in the same room or in a car with someone who was smoking cigarettes. Exposure in the past seven days was significantly related to whether the student lived with a smoker (see Table 4).

Furthermore, an association was found between living with a smoker and prevalence of cigarette smoking. The prevalence of current cigarette smoking by middle and high school students almost doubles when a student lives with someone who smokes (26% vs. 14%). Similarly, a linear relationship exists between current cigarette smoking behavior and the number of close friends who smoke.



| Category                                                                               | Any* Tobacco Use |        | Cigarette Use |        | Cigar Use |        | Bidi Use |        | Smokeless Tobacco Use |        |
|----------------------------------------------------------------------------------------|------------------|--------|---------------|--------|-----------|--------|----------|--------|-----------------------|--------|
|                                                                                        | %                | 95% CI | %             | 95% CI | %         | 95% CI | %        | 95% CI | %                     | 95% CI |
| <b>Gender</b>                                                                          |                  |        |               |        |           |        |          |        |                       |        |
| Male                                                                                   | 20.4             | 2.4    | 9.9           | 1.9    | 11.0      | 1.4    | 8.7      | 1.3    | 5.7                   | 0.9    |
| Female                                                                                 | 17.3             | 2.2    | 11.0          | 2.0    | 7.5       | 1.2    | 7.1      | 1.5    | 2.9                   | 0.9    |
| <b>Race/Ethnicity</b>                                                                  |                  |        |               |        |           |        |          |        |                       |        |
| White                                                                                  | 17.1             | 2.5    | 9.9           | 2.2    | 8.5       | 1.2    | 6.0      | 1.0    | 3.4                   | 0.7    |
| African-American                                                                       | 23.5             | 2.8    | 10.2          | 3.1    | 10.8      | 1.8    | 12.4     | 2.2    | 7.5                   | 2.1    |
| Hispanic                                                                               | 23.0             | 2.4    | 14.4          | 2.9    | 11.5      | 1.9    | 11.1     | 2.4    | 5.1                   | 1.5    |
| <b>Grade</b>                                                                           |                  |        |               |        |           |        |          |        |                       |        |
| 7                                                                                      | 14.4             | 1.7    | 6.4           | 1.1    | 7.7       | 1.2    | 6.6      | 1.2    | 3.7                   | 0.8    |
| 8                                                                                      | 23.3             | 2.7    | 14.6          | 2.4    | 10.8      | 1.4    | 9.2      | 1.4    | 4.9                   | 1.1    |
| <b>Total</b>                                                                           | 18.9             | 2.1    | 10.5          | 1.8    | 9.3       | 1.0    | 7.9      | 1.2    | 4.3                   | 0.8    |
| * Includes cigarettes, cigars, bidis, or smokeless tobacco; CI is confidence interval. |                  |        |               |        |           |        |          |        |                       |        |

Table 1. Thirty-day prevalence of tobacco use among New Jersey middle school students by gender, race/ethnicity, and grade. Thirty-day prevalence is defined as tobacco use on one or more of the 30 days preceding the survey.

Current cigarette use is lowest (4.8%) among students who have no close friends who smoke and highest (65.9%) among students whose four closest friends all smoke.

#### Cessation among Smoking Youth.

Among current established (i.e., those smoking more than five packs in lifetime) cigarette smokers, more than half (55%) express an interest in quitting and report a serious quit attempt in the past year (51.3%). Additionally, self efficacy (i.e., the belief that they could quit) among those wanting to quit is low; almost half (43.4%) did not think they could successfully quit smoking cigarettes. Nicotine dependence among smoking youth is notable; more than a third (40.5%) of current established smokers indicated they cannot go more than

three hours before needing a cigarette. Finally, half (49.5%) of the current established smokers who had seen a doctor in the past year report that they were not asked about their smoking behavior.

#### Conclusions

NJYTS results begin to make evident the tasks necessary to achieve the goals of the New Jersey Com-

**AFRICAN-AMERICAN HIGH SCHOOL STUDENTS HAD A SIGNIFICANTLY LOWER PREVALENCE OF CURRENT CIGARETTE USE THAN WHITE OR HISPANIC STUDENTS.**

prehensive Tobacco Control Program. Each program goal with implications from the NJYTS is detailed in the following sections.

**To Decrease Initiation of Tobacco Use by Youth.** A diverse menu of programs that address all age levels within the schools and community must be available as part of a successful comprehensive tobacco control plan.

The higher-than-expected levels of youth use of cigars, bidis, and smokeless tobacco demonstrate that effective tobacco control programs must focus on the risks and industry manipulation of all tobacco products, not just cigarettes. Both middle school and high school students use tobacco products in sizable numbers and as such, tobacco control programs in the schools and communi-

| Category                                                                               | Any* Tobacco Use |        | Cigarette Use |        | Cigar Use |        | Bidi Use |        | Smokeless Tobacco Use |        |
|----------------------------------------------------------------------------------------|------------------|--------|---------------|--------|-----------|--------|----------|--------|-----------------------|--------|
|                                                                                        | %                | 95% CI | %             | 95% CI | %         | 95% CI | %        | 95% CI | %                     | 95% CI |
| <b>Gender</b>                                                                          |                  |        |               |        |           |        |          |        |                       |        |
| Male                                                                                   | 42.3             | 3.4    | 26.4          | 3.0    | 24.2      | 2.1    | 16.7     | 2.3    | 15.6                  | 2.2    |
| Female                                                                                 | 35.0             | 2.6    | 28.4          | 3.3    | 12.6      | 1.8    | 11.1     | 1.7    | 5.4                   | 1.2    |
| <b>Race/Ethnicity</b>                                                                  |                  |        |               |        |           |        |          |        |                       |        |
| White                                                                                  | 42.6             | 3.1    | 33.1          | 3.0    | 19.9      | 1.7    | 12.1     | 1.6    | 11.1                  | 1.6    |
| African-American                                                                       | 34.3             | 4.7    | 15.2          | 3.5    | 16.8      | 2.6    | 16.2     | 3.1    | 10.5                  | 3.4    |
| Hispanic                                                                               | 36.4             | 5.1    | 26.1          | 5.6    | 17.1      | 3.1    | 18.0     | 4.5    | 10.1                  | 3.3    |
| <b>Grade</b>                                                                           |                  |        |               |        |           |        |          |        |                       |        |
| 9                                                                                      | 32.3             | 2.9    | 19.7          | 2.7    | 16.1      | 1.8    | 12.8     | 2.2    | 10.4                  | 2.2    |
| 10                                                                                     | 36.9             | 3.4    | 26.3          | 4.0    | 18.0      | 2.2    | 13.5     | 2.3    | 10.5                  | 2.2    |
| 11                                                                                     | 42.5             | 3.5    | 31.2          | 4.0    | 21.5      | 2.7    | 16.1     | 3.2    | 10.0                  | 1.8    |
| 12                                                                                     | 45.0             | 4.4    | 34.6          | 4.7    | 17.5      | 2.9    | 13.6     | 1.9    | 11.6                  | 2.3    |
| <b>Total</b>                                                                           | 38.9             | 2.4    | 27.6          | 2.6    | 18.4      | 1.3    | 14.1     | 1.6    | 10.7                  | 1.4    |
| * Includes cigarettes, cigars, bidis, or smokeless tobacco; CI is confidence interval. |                  |        |               |        |           |        |          |        |                       |        |

Table 2. Thirty-day prevalence of tobacco use among New Jersey high school students by gender, race/ethnicity, and grade. Thirty-day prevalence is defined as tobacco use on one or more of the 30 days preceding the survey.

ty must address the needs of youth of all ages. More research is needed to understand why youth who know the risks and may even overestimate the risks of using tobacco still initiate use. While not a focus of the NJYTS, young adults (ages 18 to 24) also need the support of a comprehensive tobacco control program. As youth programs gain success and the rate of youth initiation decreases, it will be important to ensure that tobacco product manufacturers do not begin to target college students and young adults to replace the future revenues they are losing from a reduction in youth tobacco use.

**To Reduce Disparities Related to Tobacco Use among Different Population Groups.** Programs that target specific racial and ethnic

populations in New Jersey and address the pertinent issues of each particular group must be part of a comprehensive tobacco control plan. NJYTS data has demonstrated that different segments of the population are affected by tobacco in distinct ways. Previous data has shown that white high school

**ALMOST HALF (44%) OF  
THE STUDENTS REPORT  
THAT THEY LIVE WITH  
SOMEONE WHO SMOKES  
CIGARETTES.**

students have higher cigarette smoking rates than African-American high school students, although the difference in the level of use has been decreasing since the early 1990s.<sup>9</sup> It is unclear why white, African-American, and Hispanic New Jersey middle school students are using tobacco at similar rates, while in high school, white students are still using tobacco at higher rates. Racial and ethnic differences also exist in the use of bidis and smokeless tobacco—African-American students have higher prevalence rates.

One area that may affect these disparities relates to targeted marketing. Even among the youngest cigarette users, 9 out of 10 have a preferred brand. The decision to



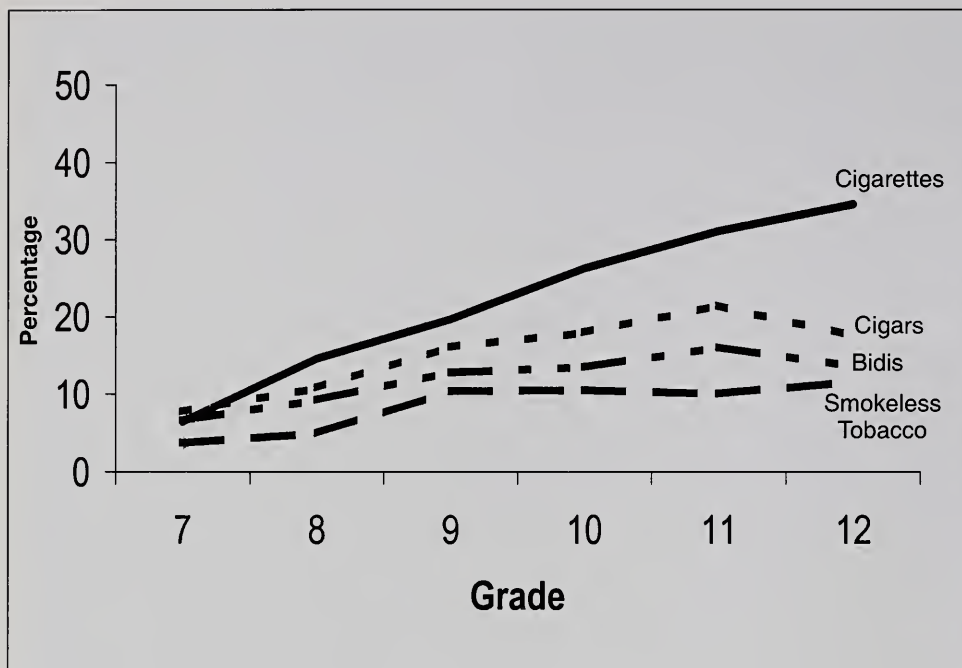


Figure 1. Tobacco Prevalence by School Grade.

smoke one brand over another appears to be affected by the race of the youth. Future research is clearly warranted to understand the relationship of marketing to specific audiences and brand use. There are also a number of additional complicated factors such as socioeconomic and access to care that need to be reviewed to ensure that new tobacco control initiatives in New Jersey will be effective and appropriate for different population groups.

**To Reduce Exposure to Environmental Tobacco Smoke (Secondhand Smoke).** Tobacco affects not only those individuals who use it but also those around them. Youth who are exposed to environmental tobacco smoke (ETS) are more at risk of contracting diabetes and serious respiratory problems including asthma, pneumonia, and

bronchitis.<sup>10-13</sup> As mentioned earlier, youth living with tobacco users are significantly more likely than other youth to be exposed to tobacco smoke and more likely to smoke themselves. Physicians and other health professionals have the opportunity to counsel their adult patients about the risks of their tobacco use to other people,

**NICOTINE DEPENDENCE AMONG SMOKING YOUTH IS NOTABLE; MORE THAN A THIRD (40.5%) OF CURRENT ESTABLISHED SMOKERS INDICATED THEY CANNOT GO MORE THAN THREE HOURS BEFORE NEEDING A CIGARETTE.**

specifically their children who reside with them, and urge them to seek treatment. In addition, by designating more public places as smoke-free, fewer youth will be exposed to ETS. The New Jersey Comprehensive Tobacco Control Program has targeted ETS through policy changes and through a community network of local initiatives as a way to reduce the impact of tobacco on New Jersey youth.

**To Decrease the Acceptability of Tobacco Use.** Tobacco use is associated with several factors. Youth who live with others who smoke or have friends who smoke are significantly more likely to be current smokers than other youth. Program components are broad-based to provide the most opportunities for inclusion of all at risk of having tobacco-related problems. This includes integrated programs in the schools and communities, treatment options, and the development of a statewide youth corps. In addition, there are multiple bridges across all aspects of this comprehensive program that allow for the components to build on each other, creating a stronger program with many partners working to prevent youth initiation of tobacco use.

**To Increase the Initiation of Tobacco Dependence Treatment among All Tobacco Users, Including Youth.** Tobacco dependence treatment programs that are specifically geared

| Brand          | Race/Ethnicity |                  |          |      |
|----------------|----------------|------------------|----------|------|
|                | White          | African-American | Hispanic | All  |
| Marlboro       | 40.7           | 7.7              | 17.2     | 30.8 |
| Newport        | 31.9           | 71.7             | 62.2     | 43.5 |
| Camel          | 4.8            | 3.9              | 4.6      | 4.8  |
| Virginia Slims | 1.0            | 2.2              | 3.0      | 1.8  |
| Other brand    | 11.2           | 3.6              | 6.3      | 9.4  |
| No usual brand | 10.6           | 10.9             | 6.8      | 9.7  |

Table 3. Usual Cigarette Brand by Race and Ethnicity.

to helping youth to stop using tobacco and are readily available and accessible are unquestionably needed as an integral component of a comprehensive tobacco control plan. In New Jersey, through the NJYTS, youth have demonstrated that they are interested in quitting tobacco use. Many youth tobacco users want to stop but do not believe that they can. Youth smoking cessation treatment is an unmet need; few programs currently exist specifically for youth.

In addition, during yearly physicians and other health-related visits, physicians and other health professionals have a "teachable moment," an opportunity to speak with youth about the issues surrounding tobacco use. Many of the youth tobacco users reported that their physicians did not always ask them about their tobacco history. Physicians need to interact with their adult and youth patients and counsel them as to the

dangers of tobacco and the need to stop. Health professionals also need to know what options and programs patients have available to them to help them quit using tobacco.

Physicians and other health care professionals can take an active role

**THE HIGHER-THAN-EXPECTED LEVELS OF YOUTH USE OF CIGARS, BIDIS, AND SMOKELESS TOBACCO DEMONSTRATE THAT EFFECTIVE TOBACCO CONTROL PROGRAMS MUST FOCUS ON THE RISKS AND INDUSTRY MANIPULATION OF ALL TOBACCO PRODUCTS, NOT JUST CIGARETTES.**

in this program on several distinct levels. First, in clinical practice, following the Agency for Health Care Policy and Research's evidence-based clinical practice guidelines on cessation can have significant impact; brief advice by health care providers to quit smoking is effective." Second, health providers can serve as a resource for tobacco-related services offered in one's area. Finally, as members of a community, physicians and health care professionals can have an impact by joining local coalitions and serving as expert resources for the grassroots movement.

The new and expanded programs of the Comprehensive Tobacco Control Program will include multiple components to address the five program goals. Web-based and telephone quit lines will be set up to help individuals with the quitting process. More intense therapy will be available for individuals unable to quit using the telephone/Web-based counseling. Communities will have outreach programs to educate the public on the risks of tobacco for the user as well as the risk for the individuals who are forced to breathe the smoke. New smoke-free public place policies will be encouraged. Finally, a new media campaign will focus on New Jersey youth and young adults and their needs and wants in a campaign that will help reduce the damage caused by tobacco.



| Type of Exposure                                          | Lives with a Smoker |     |
|-----------------------------------------------------------|---------------------|-----|
|                                                           | Yes                 | No  |
| Days in past week in room with someone smoking cigarettes | 3.8                 | 1.2 |
| Days in past week in car with someone smoking cigarettes  | 2.8                 | 0.9 |

Table 4. Mean Days of Exposure to Cigarette Smoke by Living with Smoker.

## Acknowledgement

Our utmost appreciation goes out to the superintendents, principals, teachers, and students of NJYTS high schools and middle schools. We thank Commissioner Christine Grant of DHSS and Commissioner David Hespe of the New Jersey Department of Education for their support. Finally, we thank Wick Warren and Eric Pevzner, CDC-Office on Smoking and Health, for their expert guidance. The NJYTS was supported by contract number 4240 6000696 with the NJ DHSS.

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commissioner at the New Jersey Department of Health and Senior Services-Office of the Commissioner.

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# The Economic Impact of the Pharmaceutical and Medical Technology Industry in New Jersey

*William H. Tremayne*

New Jersey has long been recognized as the geographic center of the pharmaceutical and medical technology industry. It is home to more pharmaceutical companies than any other state, or any country in the world.

A December 1999 survey conducted by PricewaterhouseCoopers (PwC) for the HealthCare Institute of New Jersey (HINJ), based on 1998 data, documents the importance of the industry to the state's economy as well as to the world of research and medicine. A concentration of industry leaders in New Jersey's cure corridor is reflected in the state's preeminence in drug discovery and medical technology development. Because these companies do so much business with other New Jersey companies, the aggregate support of jobs in the state is far more extensive than previous surveys

had indicated. In addition, the anchoring presence of the industry continues to lead new companies, particularly in the emerging biotechnology industry, to locate in New Jersey to capitalize on the benefits of proximity within the cure corridor.

The total economic impact is portrayed in Table 1.

## **More Than 140,000 Jobs Created**

More than 140,000 New Jersey jobs are attributable to the presence of the pharmaceutical and medical technology industry in New Jersey. This number includes 57,629 HINJ-member employees and 43,716 employees in jobs outsourced to companies that serve HINJ members, for a total of 101,345 jobs directly related to the industry.

Applying formulas used by the New Jersey Department of Treasury, PwC determined that employment

within the industry creates an additional 40,000 jobs in the state across a wide range of industries. In total, the pharmaceutical and medical technology industry supports more than 140,000 jobs in New Jersey.

## **Research and Development Expenditures Rise**

The study also found that research and development expenditures by HINJ members rose 29% in 1998 from 1997 levels. HINJ member companies together represent 50% of research and development spending worldwide by the industry.

Within the institute's membership, nearly one quarter (24%) of New Jersey's jobs are in research and development. This amounted to 12,264 jobs in 1998.

Money spent on research and development also benefits other New Jersey institutions. Institute members paid more than \$55 mil-



|                                     |                       |
|-------------------------------------|-----------------------|
| Employee Wages and Salary           | \$4.3 Billion*        |
| Value of Shipments                  | \$1.27 Billion        |
| Capital Expenditures                | \$1.22 Billion*       |
| Contracted Services                 | \$1.35 Billion*       |
| Manufacturing Vendors and Suppliers | \$640 Million         |
| Employee and Retiree Benefits       | \$610 Million         |
| Utilities and Rental Leases         | \$330 Million         |
| State and Local Taxes               | \$242 Million*        |
| Sample and Indigent Drug Programs   | \$160 Million         |
| Medicaid and PAAD Rebates           | \$65 Million*         |
| Charitable Contributions            | \$73 Million*         |
| Other Employee Income               | \$30 Million          |
| <b>Total 1998 Economic Impact</b>   | <b>\$10.3 Billion</b> |

Table 1. 1998 Economic Impact. \*Updated with 1998 data. Other data is from 1997.

lion in 1998 to academic research institutions and contract research organizations in the state.

The industry's commitment to research is underlined by a \$1.2 billion capital expenditure in 1998. Much of this was dedicated to expansion of research and development facilities.

### Industry Encourages Development of CROs

The presence of the industry here has encouraged the development of a new industry: the contract research organization, or CRO.

The 20 member companies of the HealthCare Institute paid more than \$40 million to CROs in 1998. This is a growing portion of the industry's total R&D budget.

CROs are used to design and conduct clinical trials, test new products for safety and efficacy, and prepare data for US Food and Drug

Administration (FDA) approvals. Pharmaceutical companies have found that outsourcing is often more cost- and time-efficient than performing these functions in-house.

Twenty-five CROs are located in New Jersey, with approximately 2,400 employees.

**NEW JERSEY COMPANIES  
ARE DEMONSTRATING THAT  
MEDICAL ADVANCES ARISE  
FROM STRONG,  
CONCENTRATED  
INVESTMENT IN ONGOING  
RESEARCH AND STATE-OF-  
THE-ART INFRASTRUCTURE.**

### NJ Pharmaceutical Sales More Than \$100 Billion

The end result of these investments in research can be seen in new sales figures for institute members. Collectively, these companies sold more than \$108 billion in prescription pharmaceuticals, which represents 36% of the world pharmaceuticals market. Among other major findings in the study were that in 1998:

- Institute members contributed more than \$73 million to community and charitable organizations in New Jersey.
- Total payroll for institute members was \$4.3 billion.
- Member companies had 819 compounds under development and they sponsored 2,937 clinical studies.
- The Institute's members registered 2,381 patents.

New Jersey companies are demonstrating that medical advances arise from strong, concentrated investment in ongoing research and state-of-the-art infrastructure. These companies developed 17 of the 40 new drugs approved by the FDA in 1999. As the nation's leader in new drug development, New Jersey can look forward to a future filled with medical advances for the world, as well as major economic benefits for the state.

William H. Tremayne is president, HealthCare Institute of New Jersey, New Brunswick.

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# Web-Based Technology: What Every Physician Practice Needs to Know

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Adam H. Dublin

**T**he Internet has rapidly emerged as an important new tool for promoting personal health and disease self-management.<sup>1</sup> Several profound transitions in the culture of health care delivery are occurring in terms of growing individual responsibility and social acceptance of the Internet. The journey from provider-centric models of office-based primary care and intervention services to a vast and often confusing world of patient-centric self-management tools accessed through the Internet has not been without hazards. In addition to medical privacy and confidentiality concerns, multiple health service issues confront health care consumers, who suddenly have user-friendly tools and around-the-clock access to health care information cyberpharmacies, telemedicine and disease state management sites, interactive self-assessment tools, and virtual systems of self-referral. Fortunately,

there have been few examples of overt abuse and fraud, although regulatory challenges now confront the online pharmaceutical dispensing industry on the grounds of patient safety.<sup>2,3</sup>

This article seeks to focus specific attention on the innovative features of online self-management systems designed for consumer use with minimal medical supervision. To be sure, health consumer information technology made available in recent years does not replace the role of the health care provider. However, the newest generations of smart tools for patient-centric medical management are being designed to augment the traditional provider role. Can this medium be used effectively and responsibly by providers, payors, and patients to reduce health care costs, improve patient outcomes, promote self-management, and, ultimately, increase satisfaction with health care?

The answer to this question lies in how well Internet-based self-management systems accommodate physician roles and address efficacy, privacy, cost, and equity concerns.

## Physician Roles

How are providers becoming involved in the primary and specialty care of patients who self-select themselves as participants for Internet-based self-management? Within the model of primary care, physicians supervise and manage patients using clinical judgment, cognitive reasoning, and evidence-based protocols for planning treatments, referrals, and interventions. There have been recent instances where use of the Internet by patients soliciting *unsupervised* health information services has become a challenge to primary care physicians.<sup>4</sup> More and more, however, responsible Web-based health management applications are beginning to acknowledge the role of the physician as the focus of coordinated



patient care.<sup>5</sup> Physicians are beginning to augment traditional care models by using Internet-based applications to facilitate the exchange of health information with patients and to track illness and measure outcomes. When successfully implemented, these powerful new interactive tools can have a positive impact on health care delivery both clinically and economically.

As an example, some Web-based personal health management services provide an interactive set of applications for patient self-assessment and self-management as well as a host of technologies designed to facilitate patient-physician communication that transform the physician-patient relationship and the way people track and monitor their health status.<sup>6</sup>

The latest generation of Web applications is integrating e-health technology into traditional primary care transactions. Through their physician, patients receive targeted, personalized instructions—tools to help them measure, monitor, and maintain health—and a wealth of health care content designed to facilitate positive, patient health care behavior and tools to communicate effectively and efficiently with their physicians. Physicians leverage these e-health applications to strengthen their relationships with patients,

proactively manage patients' health, create administrative efficiencies, and capture outcomes data.

Unfortunately, many systems today are less effective because they have failed to engage both patients and physicians: they are too costly to implement, require substantial physician behavior modification, or have not provided a compelling payoff for patient participation.

### Efficacy

To assess the impact of online self-management services provided by health-related Web sites, new tools and survey instruments are being developed to measure patient-reported health outcomes. The sci-

entific test of the efficacy of Internet-based disease management tools will require the use of advanced psychometric instruments capable of linking patient-reported improvements in functional status and quality of life to specific Web-based interventions.<sup>7</sup> An entire arm of health services research science is currently validating health-related quality-of-life instruments that measure clinical efficacy and patient acceptance of Web-based interventions.

Recent pilot studies using Internet-based disease self-management tools, however, have shown positive results. In one study, asthma patients from a low-income urban community without computer knowledge or experience were provided portable spirometers and palm-sized data loggers for tracking peak flow and transmitting symptoms and lung function measures to a trained clinician.<sup>8,9</sup> Most of the pilot group of patients (82.4%) reported that self-monitoring procedures using Internet-based communications were "not complicated at all." Almost the entire pilot test group (94.1%) demonstrated interest in using home asthma telemonitoring and self-management to improve their functional status and quality of life.

CAN THE INTERNET BE  
USED EFFECTIVELY AND  
RESPONSIBLY BY  
PROVIDERS, PAYORS, AND  
PATIENTS TO REDUCE  
HEALTH CARE COSTS,  
IMPROVE PATIENT  
OUTCOMES, PROMOTE  
SELF-MANAGEMENT, AND,  
ULTIMATELY, INCREASE  
SATISFACTION WITH  
HEALTH CARE?

## Privacy

Are Internet sites sufficiently secure and tamperproof to facilitate sensitive data collection for multiple purposes, including electronic patient record maintenance, health risk assessments, provider-patient communications, and patient-reported symptoms and health outcomes? There is growing national concern over medical privacy as both the mechanisms for data collection and end use of confidential medical data grow increasingly complex and electronic. Federal initiatives begun in response to the Health Insurance Portability and Accountability Act (HIPAA) have proposed new rules to monitor and regulate the privacy of health information.<sup>10</sup> Proposed for full implementation in 2000, these rules will set new restrictions on the use and disclosure of health information and establish new consumer rights, penalties for misuse of health information, and legal remedies for those injured by the misuse of their medically confidential information.

Web sites offering health and disease self-management services routinely collect health information that is subject to the HIPAA regulations as proposed for implementation. This essentially requires that health Web sites maintain a system whereby health information they collect from visitors is carefully

## THE LATEST GENERATION OF WEB APPLICATIONS IS INTEGRATING E-HEALTH TECHNOLOGY INTO TRADITIONAL PRIMARY CARE TRANSACTIONS.

guarded to prevent intentional or inadvertent disclosure and is maintained in accordance with "good housekeeping" rules for ensuring the medical privacy of individuals.

Privacy may well become the central focus of health-based Internet sites as they attempt to differentiate themselves from competitors with an emerging array of new services and tools. Almost all Internet sites related to health have developed privacy policies designed to protect medically confidential information from inadvertent disclosure. In a recent study commissioned by the California HealthCare Foundation, researchers rated health Web sites based on their stated privacy policies and how medically sensitive information provided by visitors is protected.<sup>11</sup>

The explosion of Internet-based health Web sites may catalyze the public debate regarding privacy and confidentiality of all personal infor-

mation. It is assumed that the outcome will be Web sites that pay closest attention to medical privacy in both theory and in practice will inevitably emerge as leaders.

## Cost

Internet access has reached nearly three-fourths of all US households during the past 10 years. Large companies such as Ford Motor Company have announced plans to purchase personal desktop computers configured for easy access to the Internet for all their employees. Standard desktop configurations allowing such access sell today for less than \$1,000, with some Internet service providers (ISPs) bundling their software and three-year contracts with desktop systems that retail for less than \$500. The vast majority of ISPs (e.g., MSN, AOL, and EarthLink) currently charge monthly usage fees of \$20 for unlimited 24-hour-a-day access to the Internet. Many employees have Internet access on the job, and primary and secondary schools are all moving quickly to provide students with access as well (most colleges already do).

Because of this widespread access, the costs for developing and updating health Web sites are borne by advertisers, including managed care organizations, pharmaceutical com-



panies, computer and software manufacturers, and a host of other interested parties. In an effort to make the Internet the universal mechanism for health care transactions, these underwriters are pouring money into ensuring the participation of health care providers and their patients in future health care transactions.

Equity

Unfortunately, access to the Internet is not equal among various sociodemographic groups in our society. A recent survey of 132 emergency department patients showed that access to both Internet and e-mail services were, in fact, determined by income and racial or ethnic characteristics. Income and Internet connectivity were highly correlated among these respondents, with white patients being much more likely to have Internet access and e-mail accounts compared with nonwhites.<sup>12</sup> The surveyors concluded that Internet access is directly correlated with income and that current patterns of Internet access are distributed unevenly with respect to race and ethnicity. Equity in access to health care has long been a consideration that directly focuses on the individual's right to medical care. Internet-based health self-management tools have the potential

to broaden access to health information. Yet those in greatest need of such services may lack the means to participate.<sup>13</sup> Many would argue that cost-effectiveness may be the deciding factor in determining the threshold level of access to health care services that are considered a social right. If interactive electronic medical systems prove to be both clinically effective and cost-efficient, they may be viewed as necessary enhancements to primary care purchased by both commercial and government third-party payors.

In Summary

Internet-based self-management tools are rapidly coming of age. In

TODAY, THE INTERNET IS  
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their infancy, public and professional concerns focused on medical privacy and widespread access to an emerging electronic technology for enhancing the delivery of health care. Today, the Internet is rapidly becoming a source of fully featured clinical tools, enabling physicians to better manage their patients and improve treatment outcomes for a growing number of illnesses and disease states. Web-based patient self-management tools are not only effective but also satisfying and desirable to consumers. Although issues still remain concerning privacy and distribution of resources, an increasing number of physicians are finding that their patients are eager to participate in Web-based interventions. In addition to wellness management, Web-based applications have emerged as best clinical practice models for patient-centric disease state management.

Consumers are leading this revolutionary transformation. Many large health insurers have responded by reinventing member care using e-commerce solutions that address benefits management and geographic access to primary care and specialty providers and provide help in building self-management skills needed to set and achieve realistic health goals for themselves and their families. The science of medical

outcomes assessment has advanced during the past decade, allowing health care researchers to link specific interventions delivered through the Internet with improvements in treatment outcomes, quality of life, and patient satisfaction. For physicians, the Internet will facilitate innovative ways of reaching out to patients through electronic communications designed for monitoring both the processes and outcomes of clinical management.

Physicians can help catalyze this transformation in health care as dynamic agents of change. Ignoring this shift in emphasis toward patient self-management will result in a missed opportunity to improve the delivery of primary and specialty services and transform the role of physicians as coordinating managers of patient care and clinical outcomes.

Adam Dublin is managing director, physicians channel, the HealthSCOUT Network, a provider of consumer health information and interactive tools and an RxRemedy Inc. company headquartered in Westport CT, [www.healthscout.com](http://www.healthscout.com). He would like to thank Marty Atherton, director of analytic services, the HealthSCOUT Network, for his assistance in preparing this article.

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# Selman A. Waksman, the Garden State, and the Antibiotic Revolution

*Henry H. Sherk, MD*

**T**he land now known as New Jersey has been referred to as a garden since the 17th century. As early as 1684, European writers called it "a veritable garden" and the "garden of America," terms that imputed a somewhat paradisiacal quality to the New World colony.<sup>1</sup> While no longer thought of as an unspoiled Eden, New Jersey is still the Garden State, and despite its high population density and considerable degree of urbanization, it has kept close ties to the land and the sciences of agronomy and horticulture. In fact, the state maintains the College of Agriculture and the New Jersey Agriculture Experiment Station in New Brunswick, reflecting the continuing importance of agronomy to the state's economy. Most physicians, however, are not familiar with the investigative work conducted at these facilities, nor would they likely be aware that 50 years ago research at these sites evolved into seminal medical research that resulted in the conquering of age-old diseases that had ravaged humankind since the beginning of time. All of this came about because of the alertness and prepared minds of a group of investigators in New Jersey, of whom the central figure was Selman Waksman.

Waksman was born in the area of Russia that is now Ukraine on July 22, 1888. His parents were Jewish, and Waksman experienced firsthand the anti-Semitism and upheavals of that time and place. In 1905, factory workers and peasants in St. Petersburg marched by the thousands to petition the Russian czar for redress of the inequities and repression in their lives, but violence broke out and Cossacks were ordered to stop them. An infamous massacre ensued. This abortive 1905 Revolution apparently made Waksman realize that reconciliation of the conflicts in Russia would be impossible, and in 1910, at the age of 22, he came to the United States to live with a cousin who was a farmer in Metuchen, New Jersey.

His education in Odessa had been sufficient to prepare him for matriculation at Rutgers in 1911, from which he graduated Phi Beta Kappa with a bachelor of science in agriculture in 1915. He received an appointment as a research assistant in soil bacteriology under Dr. J. G. Lipman at the New Jersey Agriculture Experiment Station, continuing graduate work at Rutgers. He also won his master's degree in agriculture there in 1916, which was the same year he married his childhood sweetheart, Bertha



Deborah Mitnick. In 1918, Waksman earned a PhD in biochemistry at the University of California. Dr. Lipman, who was dean of the College of Agriculture, invited him to return to New Jersey, and Waksman was appointed to the position of microbiologist at the Agricultural Research Station and lecturer in soil microbiology at Rutgers.<sup>2</sup> He then began a career in scientific research that transcended the boundaries of agronomy and gave the seemingly mundane new dimensions and new directions.

Initially, Waksman directed his investigations into the microbiological populations of the soil and their effects on soil fertility, but the world was fortunate that his early research coincided with that of Fleming, Florey, and Chain in Great Britain. It will be recalled that in 1929 Sir Alexander Fleming observed that a fungus that had inadvertently blown over open agar plates left by an open window destroyed cultures of *Staphylococcus aureus*. The fungus was identified as *Penicillium*.<sup>3</sup> Fleming did not pursue the clinical possibilities of his discovery, largely because of the difficulty of producing a meaningful amount of it. He stated, "The trouble of making it seemed not worthwhile."<sup>4</sup> H. W. Florey and E. B. Chain, however, did consider the clinical potential of penicillin, and by the late 1930s they had demonstrated its effectiveness in treating infections caused by staphylococcus and various other bacteria. Mass production of penicillin was imperative but impossible, at least in a Great Britain mired in World War II, so the American pharmaceutical industry rose to the challenge.<sup>5</sup>

New Jersey has one of the greatest concentrations of such corporations in the world and is to pharmaceuticals

WAKSMAN THEN BEGAN A  
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AND NEW DIRECTIONS.

what Michigan is to automobiles and what Silicon Valley is to computers. It was therefore natural that E.R. Squibb and Sons in New Brunswick and Merck, Sharp, and Dohme in Rahway would be called on to produce penicillin in quantity. These corporations developed unique growth media, isolated higher-yielding strains of *Penicillium*, and perfected fermentation techniques in deep tanks to change the outlook for penicillin production. Because of the New Jersey pharmaceu-

tical industry, sufficient penicillin was on hand to treat the vast number of seriously injured British and American casualties in the 1944 invasion of Europe.

Waksman's proximity to and awareness of these developments placed many of his observations in a new light. For example, in 1932 he had reported that *Mycobacterium tuberculosis* could multiply in sterile soil but does not grow and is slowly destroyed in fresh nonsterile soils. Waksman concluded that certain fungi in the soil repressed the development of *Mycobacterium tuberculosis*, and throughout the 1930s and 1940s he concentrated his efforts on the investigation of these phenomena, focusing his interest on a group of saprophytic microbes known as the actinomycetes. He observed widely varying growth-inhibitory effects on a range of microorganisms and identified a group of chemical substances produced by the actinomycetes as *antibiotics*, a term for which he is generally given credit.

The first antibiotic he developed was from a culture of an actinomycete. It proved to be toxic when injected into experimental animals, but a new subgenus of the actinomycetes, which he called the streptomycetes, produced a new and distinct type of antibiotic called *streptothricin*, later changed to *streptomycin*. Waksman reported that the initial

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IN THE 1944 INVASION  
OF EUROPE.

cultures of the streptomycetes came from the soil of a New Jersey chicken farm and described an incident in which a poultry farmer noted that his chickens were not breathing properly. Fearing an epidemic, the farmer brought one of the chickens to the Agriculture Research Station in New Brunswick in August 1933. A poultry pathologist took swabs of the chicken's throat and transferred the contents to culture plates. The organisms cultured by the pathologist were sent to Waksman, who subsequently identified them as the streptomycetes. This culture spawned a whole class of antibiotics now called the aminoglycosides.<sup>6</sup> It became apparent that streptomycin and related antibiotics had an entirely different spectrum of effectiveness when compared with penicillin. These drugs could suppress the growth of gram-negative organisms (e.g., *Escherichia coli* and *Salmonella typhosa*), and they also proved highly effective against *Mycobacterium tuberculosis*. Typhoid fever and dysentery, for example, could be cured with these agents, and streptomycin became the first truly effective antibiotic in the treatment of tuberculosis. It was distributed worldwide, ending the relentless pandemics of that disease.

The importance of these discoveries could hardly be overemphasized, and the economic potential of streptomycin and related antibiotics was recognized as well as their clinical effectiveness. For Waksman, fame and fortune followed shortly. In 1952 he was awarded the Nobel Prize in physiology or medicine and given membership in the Legion of Honor of France, the Order of the Southern Cross of Brazil, the Grand Cross of Public Health in Spain, and the Order of the Star of the Rising Sun (conferred on him personally by the Emperor of

Japan). He was awarded numerous honorary degrees in medicine, science, agriculture, letters, and law from universities all over the world. Patents that he had based on these discoveries made it possible for him to receive a flood of royalties, which soon made him wealthy. It was an extraordinary turn in the fortunes of Dr. Waksman, an immigrant from Russia who spoke heavily accented English and started out as a lecturer in soil microbiology.

It was not surprising that these levels of academic and financial recognition did not sit well with his coworkers. Several of these, most notably Albert Schatz, believed they deserved at least some of the credit for the discoveries and filed suit for damages. After all, the first report on the isolation of streptomycin was published by A. Schatz, E. Bugie, and S. A. Waksman.<sup>7</sup> The courts recognized these claims and awarded his coworkers financial relief and a portion of the royalties from the various patents secured by Waksman. Waksman himself obliquely and perhaps self-servingly gave reference to these claims in his book *The Conquest of Tuberculosis*. In his words: "if you ask who was responsible for the isolation of the particular streptomycin-producing strain of streptomycetes, the answer must be that it was the chicken because it picked up the culture from the soil."<sup>8</sup> He also asks, "Was the discovery made by the poultry pathologist?" and "Was it made by the student who worked under my direction and used the methods I had developed?"<sup>8</sup> He elsewhere lists, with some denigration, a group of individuals by saying "in this work I had the help of a number of graduate students and assistants . . . it is sufficient to mention H. B. Woodruff, H. Robinson, Elizabeth S. Horning, Doris



THERE IS LITTLE DOUBT  
THAT SELMAN WAKSMAN  
WAS ONE OF THE GREAT  
INVESTIGATORS AND ONE  
OF THE GREAT MEDICAL  
SCIENTISTS OF HIS TIME,  
THE FEUDS WITH HIS  
COWORKERS NOT  
WITHSTANDING.

## Acknowledgement

The author is indebted to Dr. David Pramer and Mr. Steven Lawrence for their help in preparing this paper.

Henry Sherk is historian of the Camden County Medical Society; author of *Colleagues & Competitors: 150-year history of the Camden County Medical Society*; and professor of orthopaedic surgery, Medical College of Pennsylvania Hahnemann University, Philadelphia PA.

Jones, A. Schatz, H. Christine Reilly, Elizabeth Bugie, D.B. Johnstone, O.E. Grassle, and Dorothy R. Smith."<sup>8</sup> Elsewhere, Waksman is somewhat humbler and perhaps more accurate. "This solution came from the soil. Mother Earth brought the answer." He quotes from the book of Ecclesiasticus: "the Lord hath created medicines out of the earth and he that is wise will not abhor them."<sup>8</sup>

There is little doubt that Selman

Waksman was one of the great investigators and one of the great medical scientists of his time, the feuds with his coworkers not withstanding. He richly earned his reputation, which has been further enhanced by the establishment of the Waksman Institute of Microbiology, built and funded by the royalties obtained from the patents on streptomycin and neomycin.<sup>2</sup> He spent his final years working in that Institute. He died in 1973 and is buried in Woods Hole, Massachusetts, where he had organized a marine bacteriology division at the Woods Hole Oceanographic Institute.

Waksman's achievements were part of the revolution in medicine that occurred as a result of antibiotics: the ancient killer diseases and the terrible epidemics are no longer with us largely as a result of these discoveries. For example, lobar pneumonia, tuberculosis, scarlet fever, and syphilis are hardly known to today's physicians. Waksman was a key figure in all of this but credit must also go to Rutgers University, which educated and sustained him, the corporations that developed the means of mass production of these drugs (e.g., Merck, Squibb, and Schering Plough), and perhaps even the political entity in which it all took place, namely the Garden State.

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# Humanism Marks Academy of Medicine's Awards

*Alan J. Lippman, MD*

**T**rust. Integrity. Compassion. Service. These keywords signify the humanistic values attributed to those receiving recognition by the Academy of Medicine of New Jersey at a special awards dinner held annually in May.

Each of this year's award recipients—Joseph F. Fennelly, MD, Lester Lieberman, Ruy Lourenco, MD, and John P. Ferguson—portrays, in his own way, those particular values, thus underscoring their achievements in various segments of the health care profession.

At a time, few might argue, when economic vicissitudes characterize health care as a "distressed industry," the conduct of these individuals reinforces the basic principles of respect for persons, beneficence, and social justice, on which the practice of medicine historically is founded.

Four awards are conferred. Since 1939, the Edward J. Ill Award has been presented to "a physician of New Jersey . . . for distinguished service as a leader in the medical profession and in the community." Beginning in 1956, the Academy has presented its Citizen's Award to "a citizen or group of citizens . . . for distinguished service in the interest of the health and welfare of the community" in recognition of that segment of the lay community with a profound dedication to the principles and practices of health care and public health.

Starting in 1998, the Academy sought to recognize two other segments of the profession: the President's Medical Educator Award was presented to "a medical educator who has contributed significantly to graduate and undergraduate medical education," and the Medical Executive Award was designated for recognition of an individual "with a fundamental interest in health care and a commitment to the enhancement of medical practice."

## **Edward J. Ill Award**

Named for the Academy's first president, the Edward J. Ill Award this year was conferred on Joseph F. Fennelly, MD, of Madison. An internist, Dr. Fennelly represents the

classical humanist physician, friend and counselor, confidante and advocate, who enters the lives of his patients and their families, providing support, encouragement, and succor. He is perhaps best known for stewarding the Quinlan family through uncertain times and when few guidelines existed in an effort to provide their daughter, Karen Ann, appropriate and compassionate care. From this experience, he then went on, through stature and statute, to help craft current approaches to such matters as advance directives, palliative care, end-of-life management, and physician-assisted suicide.

Dr. Fennelly attributes his contributions in this area to improving the effectiveness of interpersonal communication and to collaboration with others in the process of shared decision making.

"Nowhere is decision making in medical ethics more critical and effective than in sharing at the bedside," says Dr. Fennelly. It was the experience of caring for Karen Ann that established the foundation for ethical decision making and the empowerment of individuals and families dealing with end-of-life issues.

"Our accomplishments in the area of medical ethics in New Jersey have come from shared decision making," adds Dr. Fennelly. "This applies to the establishment of ethics and prognosis committees, the creation of citizen's committees, landmark decisions of our prestigious New Jersey Supreme Court, and in the deliberations of our Bioethics Commission."

Dr. Fennelly concludes: "It takes many to master the art of medicine, a lesson I have learned repeatedly through my long relationship with the leadership of the Medical Society of New Jersey and the Academy of Medicine."

## **The Citizen's Award**

The Citizen's Award recipient, Lester Z. Lieberman, also exemplifies the qualities of leadership, innovation, and commitment so highly valued in the health profession. As chair of the Board of Trustees at Newark Beth Israel



Medical Center, he presided over tremendous physical growth in the past two decades. His perception and drive led to the development of an urban hospital offering state-of-the-art technological services for all as well as primary care to the citizens of Newark.

In the mid-1990s, as health care economics began to place extraordinary stresses on hospital performance, Lieberman was the principal architect of a new philanthropic foundation, committed to address the contemporary health care needs of the institution from which it was created and the community it continues to serve.

"I am deeply honored," says Lieberman, "to be the recipient of the Academy of Medicine's Citizen's Award. I am proud that my efforts to 'make a difference' are being recognized by such an important and prestigious organization."

### The Medical Educator's Award

Having served as dean of the UMDNJ-Medical School for the past 10 years, Ruy V. Lourenco, MD, recipient of the Educator's Award, now plans to retire. His tenure was marked by the institution of innovative methodologies into an enriched curriculum, stimulation of numerous research endeavors, and, especially, the recruitment and education of underrepresented minorities.

Dr. Lourenco is credited with recruiting outstanding new leadership for more than a dozen academic departments; establishing new clinical departments in family medicine, orthopedics, and neurologic surgery; developing clinical centers of excellence in neurologic disorders and infectious diseases; and tripling the funding for research.

With interests extending beyond the institution he served, Dr. Lourenco was instrumental in opening educational opportunities for underrepresented minorities. As a member of the executive committee of the American Association of Medical Colleges' (AAMC) Project 3000 by 2000, he fostered the development of "educational pipeline programs" at the New Jersey Medical School, thus contributing to the success of the AAMC's national project, whose goal

was to enroll 3,000 minority representatives into medical schools by the year 2000. These programs, supported by a variety of federal and private grants, were recognized by the AAMC with an Outstanding Community Service Award to the school in 1994.

In addition to his many administrative accomplishments, Dr. Lourenco is an outstanding clinician and scientist and author of more than 70 articles and 16 book chapters and serves on numerous national committees and editorial boards.

"I am greatly honored," Dr. Lourenco admits. "Throughout my career, my focus has been on providing high-quality education to the future physicians of this country." Further, he believes, "it is the obligation of all of us to perpetuate excellence in our profession and inculcate in our future colleagues the highest standards of professionalism and honesty."

### The Medical Executive Award

President and CEO of Hackensack University Medical Center John Ferguson, recipient of the Medical Executive Award, helped to create what is now publicly acknowledged to be one of the premier health care institutions in the United States. For more than 15 years, Ferguson has presided over one of the largest hospital expansion and renovation projects ever approved by the State Department of Health in the history of New Jersey. In conjunction with several of the nation's principal health care philanthropies, Ferguson's visions have become realities for patients, families, clinicians, and researchers, individually and collectively.

"I've been very fortunate," Ferguson acknowledges, "to have received many awards over the years, but this recognition is the one I am most proud of. As a hospital administrator, it truly is a great honor being recognized by the physicians of the Academy of Medicine of New Jersey."

The Academy, too, is honored to recognize the extraordinary achievements of all of these outstanding individuals and, by so doing, reinforcing the ideals of a profession beleaguered by a harsh economic climate.

*Alan J. Lippman is a past president of the Academy of Medicine of New Jersey.*

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INDIVIDUALS REINFORCES  
THE BASIC PRINCIPLES OF  
RESPECT FOR PERSONS,  
BENEFICENCE, AND  
SOCIAL JUSTICE.

# Mending Bodies, Saving Souls: A History of Hospitals

Guenter B. Risse  
New York: Oxford University Press, 1999  
716 pp., \$39.95  
ISBN: 0195055233

Guenter Risse has been fascinated with hospitals ever since he was a boy. In the course of preparing this book, Risse revisited many of the hospitals that he saw as a youth and that he worked in as a doctor over the past 50 years. Risse, a physician (an internist) and historian, is professor and chair of the history of health sciences department of the University of California—San Francisco. His account is by no means the history of hospitals, but it is a fascinating

interpretation of the development of the modern hospital. It is a page turner.

In a dozen chapters, Risse takes his readers from the Golden Age of Greece to the academic medical center of the 20th century. His method is unique: he introduces each healing place with the problem of a specific patient who was treated there. After he engages the reader's interest in a patient, he describes the institution where the patient is being treated (e.g., the temple of

Asclepius, the Hospital of St. John in Jerusalem, the Madison [Wisconsin] General Hospital, the AIDS ward of the San Francisco General Hospital). He situates each patient in the context of the history of the period in which he or she lived. Risse's story thus becomes a history of health and medicine, while never losing its focus on the patient and the hospital.

Risse argues that it is important to understand the history of the hospital because since the Enlightenment,



hospitals have become the main engines in the production of medical knowledge. While this point is hardly original, Risse compels the reader to pay attention with true stories of patients who lived between 145 and 1994 CE. He describes the history of the institution in which each patient is treated, interspersed with information about the patient's clinical course to recovery, convalescence, or death.

Some of Risse's best chapters, from a narrative point of view, are his stories of the Necker Hospital in Paris (where Laennec invented the stethoscope), the Massachusetts General Hospital (where the first public operations were performed under general anesthesia), the Royal Infirmary in Edinburgh (where Lister successfully resected the head of the humerus of a patient with tuberculosis), William Osler's ward at the Johns Hopkins Hospital, and the transplantation unit of the Moffit Hospital of the University of California in San Francisco. Although Risse holds the reader's interest with the words of each

patient or the description of the patient's course from the hospital record, his main purpose in this book is to show the evolution of the hospital. Arguably, the most dramatic change in the hospital occurred in the United States in the mid-20th century: as the medicalization of society progressed, hospitals were selected as the primary locus for fighting acute and potentially curable conditions. This status contrasted sharply with the previous emphasis on the chronic and incurable conditions linked to charity and dependence, not rehabilitation. Moreover, human experiences such as birth, old age, and death also became hospital-bound.

Risse's book is long and densely packed with information. It is best studied one chapter at a time, and when approached in that way it makes good reading. The book is well documented with endnotes following each chapter, and it has an excellent index. The typesetting and proofreading are of the highest quality: I found only three typo-

graphical errors in more than 700 pages of text and endmatter (on pp. 263, 478, and 600). However, the book is not the history of hospitals; it is not even a history of hospitals of the world—its focus is limited to the history of hospitals in the Near East, Greece, Rome, Germany, Austria, France, England, and the United States.

For other views of the history of the hospital, one can consult Michel Foucault's depiction of the hospital as a place of observation and confinement in *Discipline and Punish* (1975); the pioneering and contentious work by Paul Starr, *The Social Transformation of American Medicine* (1982); and Charles Rosenberg's *The Care of Strangers: The Rise of America's Hospital System* (1987). Risse's book contributes magnificent scholarship, provides documentation and discussion that lead to a clear conclusion to each chapter, and demonstrates empathy for the patients and caregivers who animate his account of a history of hospitals.

**George J. Hill, MD**

## PEOPLE IN THE NEWS

**Mark S. Zaleskiewicz, MS**, coordinator of pulmonary rehabilitation at Shore Memorial Hospital, has assumed the presidency of the Tri-State Society for Cardiovascular and Pulmonary Rehabilitation, and **James W. Ziccardi, DO**, Shore Memorial's medical director of cardiac rehabilitation, has been selected as Tri-State's cardiovascular physician liaison.



James W. Ziccardi, DO

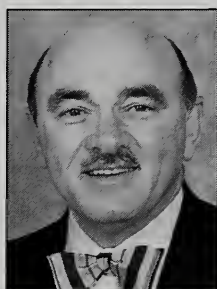
**Frederick B. Cohen, MD**, chairman of the New Jersey Commission on Cancer Research and former director of the Flo Okin Oncology Center at Newark Beth Israel Medical Center, was honored at the Newark Beth Israel Medical Center Auxiliary Gala for his support of and contributions to the medical center.

Monmouth Medical Center has appointed **Daniel J. Messina** as senior vice president and chief operating officer.



Joseph Hummel, DO

**Joseph Hummel, DO**, was named EMS Medical Director of the Year by the New Jersey Department of Health and Senior Services (DHSS), Office of Emergency Medical Services.



Jack Goldberg, MD

The Leukemia & Lymphoma Society has presented its Service to Mankind Award to **Jack Goldberg, MD**, director of the Cooper Cancer Institute of the Cooper Health System.

**Richard P. Miller**, president and CEO of Virtua Health, received the American Red Cross Good Neighbor Award.

**Betty Mazur, RN**, who works at Virtua Memorial Hospital Burlington County, received the Breast Cancer Survivor Award from the Breast Health Institute in Philadelphia.



Kenneth A. Levin, MD

**Kenneth A. Levin, MD**, Valley Hospital neurologist and medical director for the Valley Hospital Stroke Center, was part of a research team that published the results of a

nationwide study of ancrod, a drug derived from the venom of the Malaysian pit viper.

## WOMEN HELPING WOMEN CELEBRATES 25 YEARS OF SERVICE

An anniversary gala for 500 to celebrate the 25th anniversary of Women Helping Women is scheduled for September 23 at the Liberty Science Center in Jersey City. The event will honor **Yvonne Thornton, MD**, and **Lenore Walker, PhD**. For more information, call (732) 549-6000.

## SPECIALIZED BRAIN INJURY PROGRAM

Kessler Rehabilitation Corp. has announced that the Kessler Care center at Cedar Grove has received approval from the DHSS to create a specialized care program for individuals with traumatic brain injuries. The program, in affiliation with the Kessler Institute for Rehabilitation, will become a part of the Northern New Jersey Traumatic Brain Injury System. For more information, call (973) 571-6666.

## NEW REGIONAL MEDICAL CENTER RECEIVES APPROVAL

DHSS Commissioner Christine Grant gave South Jersey Hospital approval to consolidate its three acute care hospitals into a new regional medical center. For more information, call (856) 451-7547.

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## ELECTRONIC MEDICAL RECORDS FOR BEGINNERS

**P**hysician Micro Systems, Inc., has recently completed a free publication called *EMR 101: A Beginner's Guide to Electronic Medical Records*, available as a booklet or online (in pdf or HTML format). It provides an overview of the key factors that an ambulatory medical practice should consider as it moves toward electronic medical records. To order, call (800) 770-7674 or e-mail [info@pmsi.com](mailto:info@pmsi.com); to download, go to [www.pmsi.com](http://www.pmsi.com).

## CUSTOMIZED PATIENT EDUCATION ON THE INTERNET

**T**o increase patient education, many hospitals and physicians provide pamphlets and photocopied instruction sheets for their patients. Saint Barnabas Health Care System has taken a further step by implementing a customized patient education system on the Internet to create information that is tailored to each patient. Patients can access their medical information in the hospital or via the Saint Barnabas Web site from their homes. The information can also be made available to others concerned about the patient—for example, adult children who live out of state. For more information, call (973) 322-4300.

## MORE DOCTOR-PATIENT WEB CONNECTIONS

**B**AI announced the availability of the digiChart Suite of digital medical record applications, which includes digiChart, a specialty-based electronic medical record currently available for allergists, and doctorsOrders, an application that helps primary care physicians manage their patients with chronic conditions.

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mated narrative, including visit records and consult report letters; automated generation of drug interaction warnings; provider- and payor-specific formularies; and automated generation of medication orders.

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# CALENDAR

**E V E N T**

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**L O C A T I O N**

**S e p t e m b e r**

|                                                                                      |                        |                                                                    |
|--------------------------------------------------------------------------------------|------------------------|--------------------------------------------------------------------|
| <b>Advanced Seminars in Ultrasound Diagnosis</b>                                     | September 8-10         | Crown Plaza Manhattan, New York NY, (914) 921-5700                 |
| <b>Substance Abuse in Health Professionals, Treatment of Diabetes</b>                | September 13-14        | Atlantic City, (800) 940-5860                                      |
| <b>American Association of Electrodiagnostic Medicine Annual Meeting</b>             | September 13-16        | Philadelphia Marriott, Philadelphia PA, (507) 288-0100             |
| <b>Pediatrics for the Practitioner—Update 2000</b>                                   | September 14-15        | Baltimore MD, (410) 955-2959                                       |
| <b>International Craniofacial Surgery Symposium</b>                                  | September 14-17        | New York NY, (800) 766-4955                                        |
| <b>Women with Disabilities: Quality of Care</b>                                      | September 15-16        | Philadelphia PA, (610) 519-6828                                    |
| <b>Comprehensive Gynecology 2000: A Clinical Update for the Practicing Physician</b> | September 15-17        | New York NY, (201) 342-5300                                        |
| <b>Certified Coding Specialist—Physician-based Exam</b>                              | September 16           | American Health Information Management Association, (312) 233-1160 |
| <b>World Congress of Gynecology and Obstetrics</b>                                   | September 17-22        | Washington DC, (514) 286-0855                                      |
| <b>New Developments in Retinal Disease and Vitreous Surgery</b>                      | September 22           | Baltimore MD, (410) 328-5934                                       |
| <b>American College of Radiology Annual Meeting</b>                                  | September 23-27        | New York Hilton & Towers, New York NY, (703) 716-7545              |
| <b>Lung Transplantation—Update</b>                                                   | September 26           | Mount Sinai Hospital, New York NY, (212) 241-3079                  |
| <b>American College of Emergency Physicians Scientific Assembly</b>                  | September 28-October 8 | Philadelphia PA, (214) 550-0911                                    |

**O c t o b e r**

|                                                         |             |                                                       |
|---------------------------------------------------------|-------------|-------------------------------------------------------|
| <b>Clinical Endocrinology—Update 2000</b>               | October 1-4 | Philadelphia PA, (301) 941-0200                       |
| <b>Biocontaminants and Biological Production Issues</b> | October 3-4 | Hilton Alexandria Hotel, Alexandria VA (617) 630-1300 |

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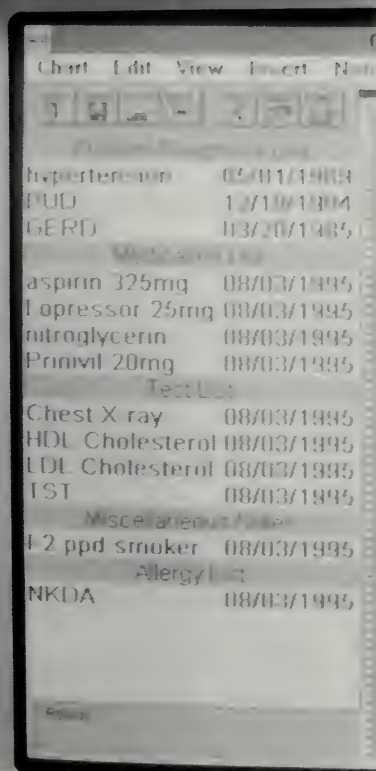
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|                                                                                      |                       |                                                                 |
|--------------------------------------------------------------------------------------|-----------------------|-----------------------------------------------------------------|
| <b>American Society of Human Genetics</b>                                            | October 3-7           | Philadelphia PA, (301) 571-1825                                 |
| <b>50th American Society of Bariatrics Physicians</b>                                | October 3-7           | Washington DC, (303) 770-2526                                   |
| <b>Lymphoma and Myeloma 2000</b>                                                     | October 5-7           | New York NY, (770) 751-7332                                     |
| <b>3rd Annual Symposium on Alternate Bearing Surfaces in Total Joint Replacement</b> | October 6-7           | Westin Hotel, Philadelphia PA, (215) 898-6400                   |
| <b>Seminar of Legal-Medical Issues</b>                                               | October 10-23         | Colonial Cruise departs New York NY, (800) 521-0076             |
| <b>1st International Geriatric Palliative Care Congress</b>                          | October 11-14         | New York NY, (514) 286-0855                                     |
| <b>The Fetus and Newborn: State-of-the-Art Care</b>                                  | October 11-14         | Crystal Gateway Marriott, Washington DC, (925) 828-7100         |
| <b>Contemporary Nuclear Cardiology</b>                                               | October 12-14         | Heart House, Bethesda MD, (301) 897-2694                        |
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# Goodbye, Abe

*Bernard Robins, MD*

Abe had had a particularly bad episode of pulmonary edema last night. The latest of several, each one coming faster than the one before had. This time—hospital—heroics—finally the breathing was easier, the lungs clearer. Abe was resting, and I had gone home.

I had known Abe for many years; treated his diabetes and watched arteriosclerotic cardiovascular disease, peripheral vascular disease, and blindness from retinopathy overtake him. But Abe had spirit . . . courage . . . pride. A widower alone in his little apartment, he took care of himself. Cooking, cleaning, taking insulin, he asked for nothing from anyone. But age and that damned diabetes kept shrinking his work and his life. Pride and independence were slipping away.

When I made rounds the next morning, Abe was the first person I visited. I entered his room, and Abe greeted me with his usual courtesy but without his usual spunk. Lying in the hospital bed, he who had been a small man seemed even more shrunken and wizened. Oxygen by nasal catheter, fluids via IV, urine into a bottle.

How are you feeling, Abe?

Pretty tired, he admitted.

Pains? No. Breathing? Okay. Spirits?

He looked toward me with his sightless eyes, and I didn't see in them what I had always seen before. Not much fight left, he choked out.

What would you like, Abe?

His answer was slow and deliberate. I want to say goodbye.

My heart flopped and my mind whirled and turned to my own father. Ill for 20 years, his condition had deteriorated badly while I was in medical school. Summoned home from classes because of his worsening state, I had flown across the country and rushed into the house only to find him silent, sightless, and still. Death had beaten me by a few minutes.

Decision made. Goodbye, Abe, I said.

He reached out his hand, and I shook it. He turned toward the wall, and as I left the room I heard him murmur: Goodbye, Doctor, and thank you.

When I reached the office about an hour later, there was a phone message from the floor nurse. Abe had died, quietly.

I had given him permission; he had given me closure; and I wept.



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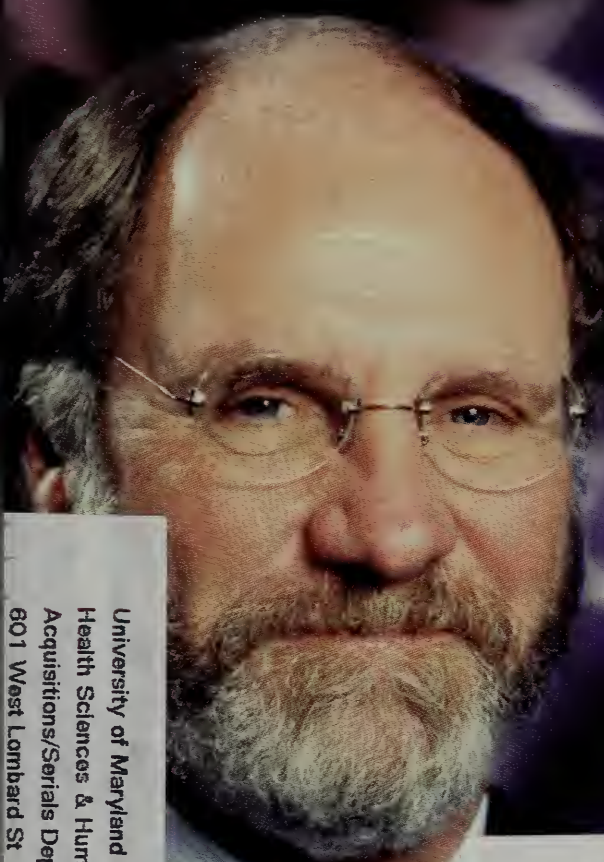
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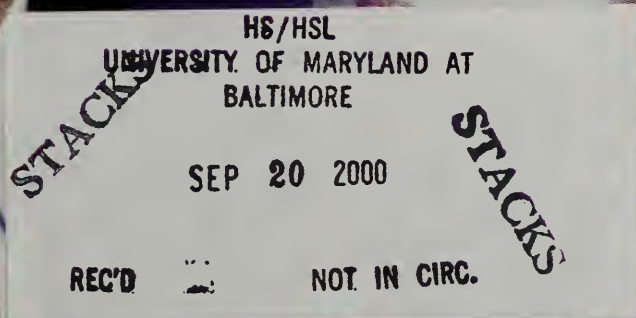
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## Managed care in Trenton, DC, and other worlds

"Like a patient who relies on her doctor for the best medical advice, I rely on MSNJ for advice on the best health care policy," asserts Governor Christie Whitman in this issue of *New Jersey Medicine*. Readers of this issue will consider candidates' potential responsiveness to physician concerns when deciding whom to support in the November 7 election.

Few governors, and probably no other Republican chief executives, have been as determined as Gov. Whitman to hold HMOs to account. She has good reason. Recent reports continue to substantiate physicians' and policy makers' concerns about managed care.

Consumer advocate Kip Sullivan, for example, argues in the latest issue of *Health Affairs* that managed care probably does not save money. Sullivan, an attorney, observes that managed care drives up payors' and providers' administrative costs. It also encourages physicians to shift costs to other

payors. "The jury," he says, "has yet to return a verdict on whether 'managed care' is more efficient than the old fee-for-service system."

**In the HMO World.** *Health Affairs* also has published a narrative by California internist Thomas Bodenheimer, who has long struggled to provide primary care in a low-income neighborhood. Bodenheimer condemns "the dysfunctional selective contracting that permeates American managed care," when "fragmentation of services is the principal feature of market pressures that drive managed care contracting."

Bodenheimer illustratively cites HMO policies that force patients to "drag themselves four miles across town" for laboratory tests, when a high-quality lab is located in the same building as the physician's office.

Here, the Whitman administration's frustrations with HMOs registered on August 16, when Banking & Insurance Commissioner Karen Suter overrode a

decision of an industry-sponsored board. Suter ordered HIP relief payments to physicians and hospitals to be sped up.

There's more. The Whitman administration has laid to rest MSNJ concerns that HMOs could terminate a physician merely by accusing the physician of fraud and abuse—and thereby circumvent the Health Care Quality Act, which

**S**upport "disruptive technologies" that allow less highly trained people to perform medical functions, plead Harvard Business School professor Clayton M. Christensen and colleagues in a recent *Harvard Business Review* article. Then, as health care costs less, we'll all consume more of it, they predict.

Drawing lessons from other industries, these medical futurists condemn both managed care and the medical establishment for resisting positive change.

generally requires a hearing before termination. The Department of Health & Senior Services has sent a bulletin to all HMOs cautioning them against terminating a physician "on a mere allegation of fraud" or a "suspicion" that is not borne out by investigation.

**In the Labor World.** Physicians employed in New Jersey by Concentra Managed Care Inc., an



occupational health service, are seeking to be represented by the AMA's new physician union, Physicians for Responsible Negotiation (PRN).

If a majority of the full-time, nonsupervisory Concentra physicians in the state vote for PRN in an election ordered by the National Labor Relations Board, they would become PRN's second bargaining unit in the nation. The first is the Wellness Plan, a Medicaid HMO near Detroit.

PRN president Susan Hershberg Adelman, MD, commented that Concentra physicians "fear some of the company's corporate policies interfere with physicians' ability to properly prescribe services for their patients."

**In the Judicial World.** Affidavits of merit, in which potential expert witnesses support plaintiffs' claims in malpractice cases, are required even when the patient's injury clearly resulted from negligence, says a three-judge panel in the appellate division of New Jersey Superior Court. Affidavits of merit are the centerpiece of tort-reform legislation enacted in New Jersey with strong MSNJ support.

The affidavit must be submitted within 60 days of the defendant's

answer to the plaintiff's lawsuit. The case involved dentists who allegedly extracted the wrong tooth of a child. Lawyers for the plaintiff relied on the doctrine of "common knowledge," or *res ipsa loquitur*, arguing that expert testimony was unnecessary, because the injury would not have occurred in the absence of malpractice.

But, said the judges, "the statute is clear and unambiguous and mandates that an affidavit of merit is required in all malpractice cases against licensed persons, including those in which a plaintiff intends to establish liability without the use of expert testimony."

Another appellate division panel has ruled that an attorney for a non-medically injured patient may not withhold payment that he promised to a physician. The physician, a neurosurgeon, had cared for the patient and furnished medical records to support a suit filed by the patient, who had been struck on the head with an axe during a tavern altercation.

Why wouldn't the lawyer pay? He was upset that the physician's payment would have to come out of the lawyer's own fee. Too bad, said the court: "Early in his career, Abraham Lincoln reportedly said, 'A lawyer's word is his bond.'"

**And the Cyber World.** "Physicians' best hopes for a prosperous and gratifying future lie in creating Internet-based partnerships with their patients," coos Richard L. Reece, MD, in an article reprinted in the *Journal of Medical Licensure & Discipline*. Dr. Reece foresees patients' expectations that physicians' Web sites will include education, appointment scheduling, health status monitoring tools, and information showing which medical services, described in other Internet locations, the physician competently provides.

Similarly, David O. Weber reports in the California-based *Health Forum Journal* on a recent conference promoting aggressive, but practical, Internet strategies by physicians. Patients will communicate electronically with physicians to obtain referrals, test results, personalized medical records, and answers to medical questions, according to the report.

Physicians' Web sites also will link patients to support groups, specialized sites, and self-care help, concludes Weber's piece, which is summarized in the *Healthcare Leadership Review*. If you're not wired, get help.

Neil E. Weisfeld

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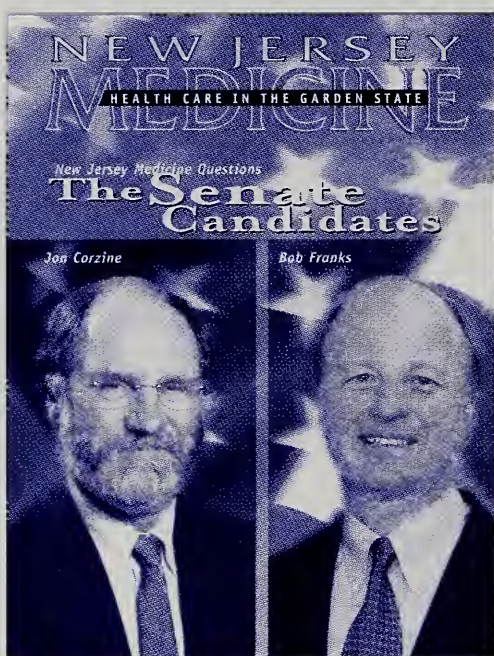
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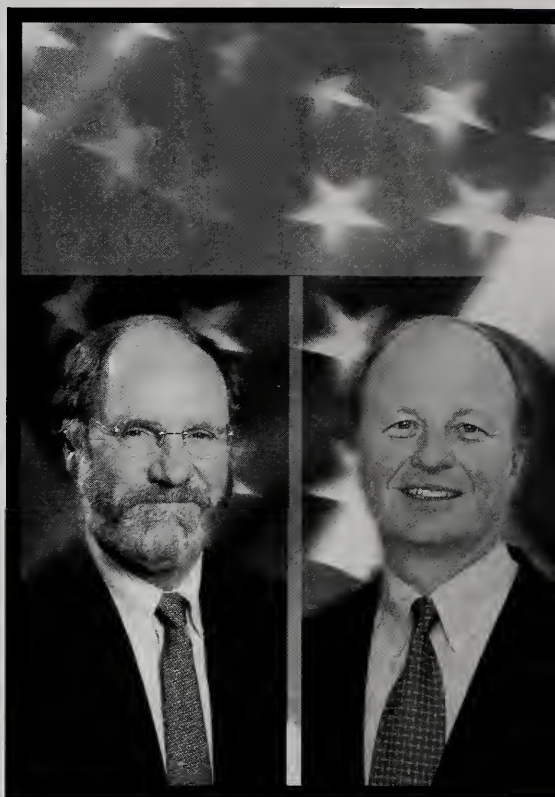
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Cover design by Three Bears LLC.

Cover photos by Corzine 2000 and Franks 2000.

### ERRATUM:

The table for "The Diabetes and Obesity Epidemic" by Arthur Krosnick, MD, was inadvertently left out of the August 2000 issue. It is posted online at [www.msnj.org/current\\_issue.shtml](http://www.msnj.org/current_issue.shtml).

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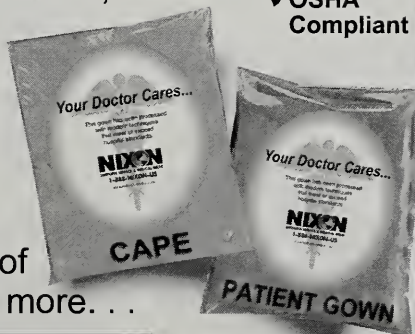
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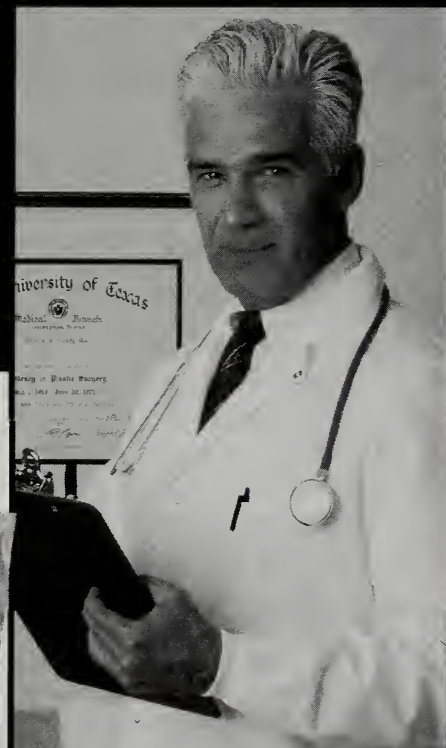


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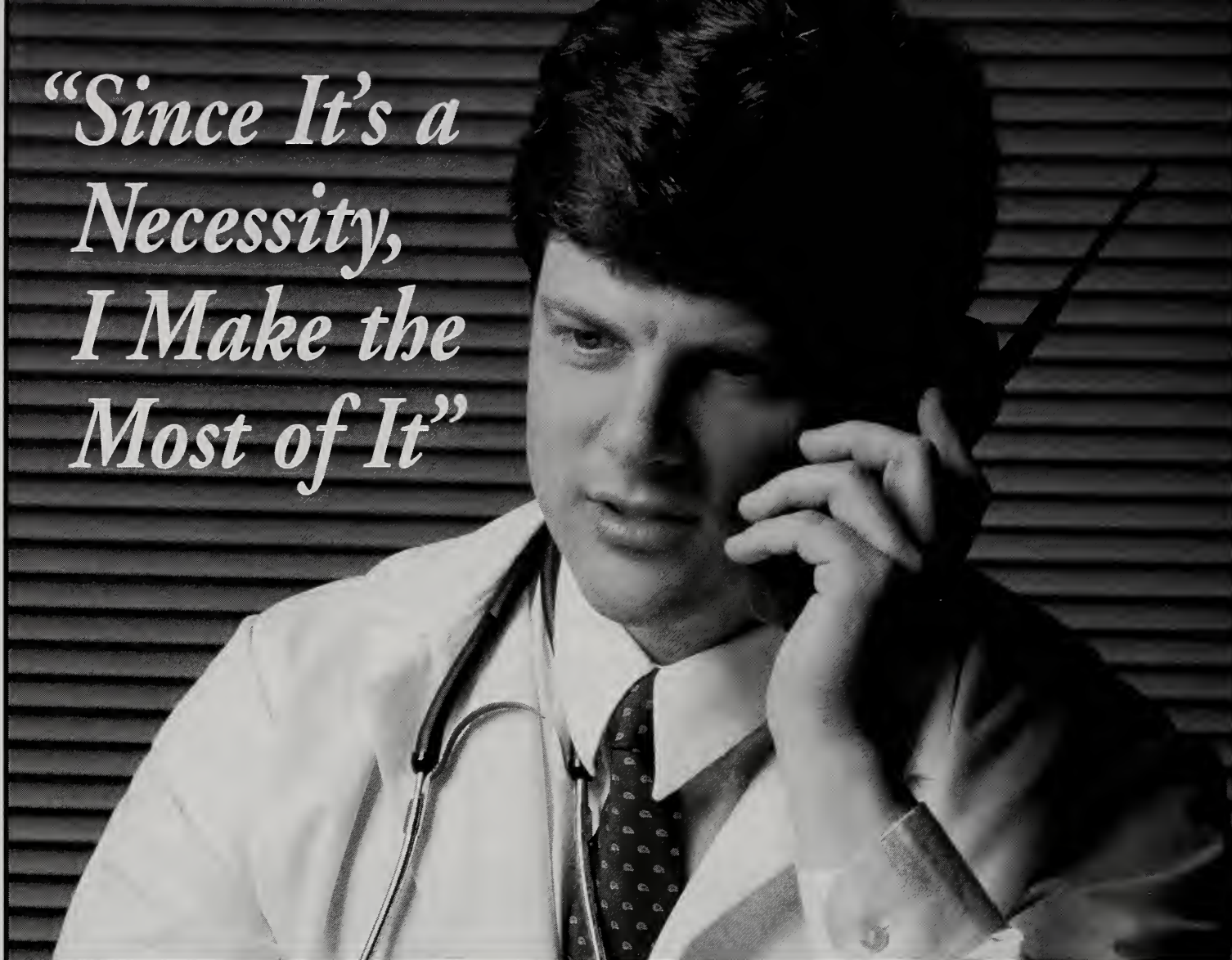


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## ELECTION DECISIONS

Postconvention voter polls show that neither George W. Bush nor Al Gore can plan on enjoying a landslide win in New Jersey. This being the case, the US Senate contest here should be decided more by the candidates themselves instead of the top of the ticket. Well, even the most casual observer couldn't help but notice how *different* Jon Corzine and Bob Franks are from one another.

One has an enormous amount of money to put his face and message in front of anyone who wants to pay attention—and even those who don't; the other will have to pick and choose where, when, and how to deliver his message. On the other hand, the one without the big checkbook is a gifted public speaker with a long history of public service, a pro-

medicine voting record, and many campaigns under his belt. The other's public speaking abilities (to be charitable) need some work, he's never held public office, and this is his first-ever campaign.

If the Republicans retain the Senate majority in the next term, it is hoped that a Franks win would persuade Trent Lott to support a decent Patients Bill of Rights. Franks voted in favor of the bill in the House of Representatives in this session. If the Democrats take over, a Corzine win could be beneficial in the same manner since more Senate Democrats than Republicans have supported such a bill.

Interesting choice. Make sure to vote on November 7th.

*Clark Martin*

## A BIOETHICIST FOR THE SUPERIOR COURT

Paul W. Armstrong, a staunch defender of the professionalism of physicians and a tireless advocate for patient's rights, was administered the oath of office as a judge of the New Jersey Superior Court on Friday, July 21, 2000, at the historic courthouse in Somerville.

Many of his friends, colleagues, and clients were present; we were moved by mixed emotions as the Honorable Thomas H. Dilts, Judge of the Superior Court, eloquently delivered the keynote address and the Honorable Robert E. Guterl, Assignment Judge of the Superior Court, administered the oath of office. The courts are gaining a brilliant, concerned, and compassionate judge, while we at MSNJ are losing our grand advocate.

Judge Armstrong is recognized nationally for his achievements in biomedical ethics. He flashed dramatically onto the scene with his dignified and spectacular representation of a family entangled in a painful tragedy that left their daughter, Karen Anne Quinlan, in a persistent vegetative state. He continued that advocacy of humane consideration

for the needs of the dying and disabled in a series of other cases. In addition, he rendered singular service to all New Jersey citizens by chairing both the Governor's Task Force on AIDS and the Commission on Biomedical Ethics.

A consummate professional, articulate, always in good humor, quick of wit, and a gentleman and a scholar, he will be relentless in the pursuit of truth and justice for all who appear in his court. He is, as one would expect, an extremely talented and multifaceted individual. It is, however, his understanding of and compassion for the human condition that sets him apart and makes him truly unique.

As noted, Judge Dilts gave the keynote address. His powerful and moving words are published in this issue, and they capture both the solemnity of the occasion and the essence of Judge Armstrong.

MSNJ extends best wishes and Godspeed to the Honorable Paul W. Armstrong, Judge of the Superior Court.

*Vincent A. Maressa*



## ANTHRAX ALERT

The article about anthrax in this issue of *New Jersey Medicine* calls attention to the potential use of this organism as a military weapon or means of unleashing bioterrorism on the civilian population. New Jersey physicians should acquaint themselves with anthrax as a disease and the agencies to involve if they are faced with a threat or an exposure. Being prepared to deal with these possibilities is our best defense. The author of the article, Maria Falca Morgan, uses her public health perspective to view these situations in her profession and her military service.

Maria Morgan was promoted to vice president of the MIIX Healthcare Group in April 2000, having joined MIIX in 1996. As vice president, she is responsible for the marketing, supervision, and delivery of consulting services.

Before coming to MIIX, Ms. Morgan was the assistant commissioner for the Division of Health Care Systems Analysis at the New Jersey Department of Health and Senior Services (DHSS). In this role, she oversaw the health planning and certificate-of-need programs, the administration of charity care for hospitals, and the management of the 22,000-member, \$50-million subsidized insurance pro-

gram, Access. Ms. Morgan spent much of her time with the DHSS in the state's maternal and child health programs, where her nursing and management background furthered the development of these programs and gained them national recognition.

As she was being promoted in her civilian life to vice president of MIIX, she was promoted to the rank of colonel in the New Jersey Air National Guard. With this honor, she became the first woman colonel in the New Jersey Air National Guard. With more than 20 years with the 108th Medical Squadron, Col. Morgan has had worldwide experiences in maintaining the health of the 1,500 members of the 108th Air Refueling Wing and lending support to other units of the Air National Guard. Col. Morgan herself has had four doses of the anthrax vaccine, and except for an expected slight fever and localized tenderness at the site of injection, she has had no complications from the vaccine.

Maria Falca Morgan's nursing, health care management, and military experience makes her uniquely qualified to alert us to the threat of anthrax.

*Leah Z. Ziskin, MD, MS*

## 2000 PERSON OF THE YEAR

The *New Jersey Medicine* Person of the Year will be announced in our December issue. Recent honorees have included Dr. Steven A. Schroeder of the Robert Wood Johnson Foundation in 1999; corecipients Dr. William Hait of the New Jersey Cancer Institute and Governor Christine Todd Whitman in 1998; and Stanley Bergen in 1997.

The selected individual or individuals may have improved the general health or health care of New Jersey citizens or influenced health policy or affected public policy in a way that would improve the well-being of people in New Jersey.

Or it may be someone in New Jersey who has had a broader impact on health care beyond the borders of New Jersey. In our selection process, we will review accomplishments over a broad period of time but will emphasize activities and events that occurred during this year.

We solicit your nominations and recommendations for our Person of the Year and will publish selected letters relating to this. Please contact us at *New Jersey Medicine*, c/o MSNJ, or by e-mail at [info@msnj.org](mailto:info@msnj.org).

*Paul J. Hirsch, MD*

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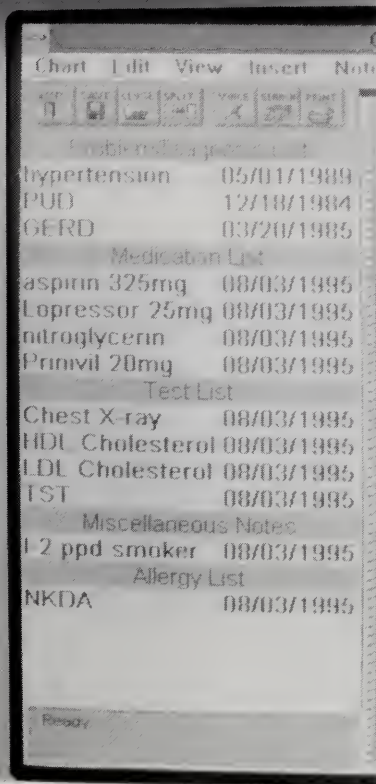
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# Trust, Efficiency, and Cooperation

## The Heart of Improving the Quality of Health Care in New Jersey

*Governor Christine Todd Whitman*

THE FOLLOWING ARE THE REMARKS OF GOVERNOR CHRISTINE WHITMAN REGARDING THE FIRST NEW JERSEY PHYSICIAN PROMPT-PAY SURVEY, THE RESULTS OF WHICH ARE ALSO PUBLISHED IN THIS ISSUE.

Earlier this year I addressed the Medical Society of New Jersey and said that physicians fight disease—they shouldn't have to fight insurance companies and HMOs. I still believe that. Assisting in the delivery of medical care is an essential role for the state government. Enacting laws that require prompt payment to medical professionals and writing soon-to-be-adopted regulations requiring HMOs and insurers to resolve disputes in a timely manner is good for everyone. It's good for doctors, it's good for patients. And, because there is due process, it's good for HMOs.

As governor, I have operated (pardon the pun) on the assumption that our health care system relies on trust and efficiency among patients, health professionals, and payors. Delays in payments, unreasonable bureaucratic hurdles, and other

process issues are unfair to everyone and can even impede the delivery of essential health services. That's why I have worked to make our health care system more efficient and fairer, and that's why I have relied on the



input of professionals—providers, hospitals, payors, and consumers—to help craft regulations that work to everyone's benefit.

As a result of our collaborative efforts, we have developed some of

the nation's most responsive HMO regulations. We've enacted landmark patient protections and are implementing our most comprehensive tobacco prevention programs ever. By working together, we have put into place the new New Jersey FamilyCare program that will expand health care coverage to 125,000 individuals who make too much money to qualify for Medicaid but not enough to afford meaningful health insurance.

Together, we have accomplished much in New Jersey, but our job is far from over. Like a patient who relies on her doctor for the best medical advice, I rely on MSNJ for advice on the best health care policy. Together, we can continue to make a difference in the quality of life in the Garden State. By continuing our partnership, we will make New Jersey a better place to live, work, and raise a family.



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# HMOs Still Avoid Meaningful Patient Care Reform

MSNJ BATTLES ON MULTIPLE FRONTS IN ITS ROLE AS ADVOCATE FOR PHYSICIANS AND THE GENERAL PUBLIC THROUGH THE MEDIA. I WISH TO SHARE WITH YOU THE FOLLOWING OPINION-EDITORIAL, WHICH HAS APPEARED UNDER MY SIGNATURE IN SEVERAL PROMINENT NEW JERSEY NEWSPAPERS. IT IS ANOTHER EXAMPLE OF HOW MSNJ STRIVES CONTINUALLY TO UPHOLD YOUR RIGHTS.

*Walter J. Kahn, MD, President, Medical Society of New Jersey*

When problems with managed care plague both patients and health professionals, large so-called health maintenance organizations (HMOs) should try to respond. That's happening, to some extent, in other states. Unfortunately, it's not happening in New Jersey.

Aetna US Healthcare is the dominant player in the HMO arena in New Jersey, with more than 660,000 patients statewide. That equals an overall 40% market share and more than 60% in some counties. Instead of using its significant influence to enhance the physician-patient relationship, however, Aetna has done quite the opposite. The company has made little effort to reduce numerous hassle factors and is extremely reluctant to implement patient-friendly procedures.

The company has adopted an almost cavalier approach to patient care in New Jersey, excluding practicing physicians in the network from the process of developing medical policies. Patient care is directly compromised as a result.

This is especially true in mental health services: the company has nearly eliminated psychotherapy by psychiatrists. Research shows that depression is best treated by a single clinician, rather than having medication checks performed by someone other than the treating (nonphysician) practitioner. Yet diagnostic interviews and 15- to 20-minute medication checks are often the full extent of a psychiatrist's involvement under Aetna's plan. As a result, Aetna patients are not getting the care they desperately need.

Aetna's lax policies are also evident outside its treatment options. For example, while the Department of Banking & Insurance (DOBI) has proposed regulations requiring all insurance carriers to set up a meaningful dispute-resolution program, Aetna has taken a far meeker approach. To comply with these regulations, Aetna US Healthcare announced the creation of a new "Problem Resolution Unit" that was to be in effect by February 2000. Half a year

later, this still has not been implemented, requiring physicians to spend more time tending to claims and appeals rather than treating their patients.

Even more disconcerting, however, is Aetna's willingness to work with physicians in other states but reticence to do so in New Jersey. Its new CEO, William Donaldson, told Connecticut physicians, "I promise a sea change in our corporate attitude toward working with your profession. We have listened to what you have been telling us."

Maybe that's the case in other states, Mr. Donaldson, but not in New Jersey. Here, nothing infuriates people more these days than dealing with health care bureaucracy, particularly that of HMOs. Surely that has something to do with why New Jersey is the only state whose entire congressional delegation voted for a strong federal patient bill of rights. Our entire delegation also supports legislation to allow independently practicing physicians to negotiate jointly with large health plans.

Aetna is by no means the only insurer that delays patient care and imposes on the physician-patient relationship. CIGNA maintains a complicated preauthorization system that requires physicians to seek permission from diverse CIGNA offices to perform medical procedures. This often results in multiple trips to a physician's office to perform a procedure that could be addressed in one office visit. And almost always, it means the physician must spend more time on the phone to receive permission for a routine procedure and less time with patients.

Regardless of the company, there are serious problems with managed care. Given its large market share in the state, Aetna has the potential and a responsibility to raise the bar for all HMOs in New Jersey. By adhering to the DOBI's proposal, Aetna could break the logjam of claims and overturn wrong decisions.

But by avoiding meaningful dispute resolution, Aetna becomes just another ineffective HMO in the eyes of New Jersey physicians and patients.



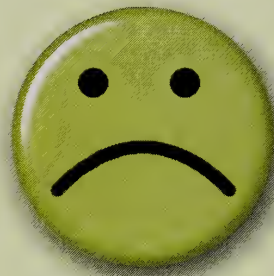
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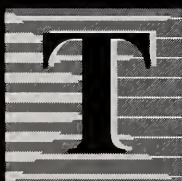
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# Changes Next Year

MSNJ prides itself on many long-standing traditions. Yet traditions should change when necessary to serve the needs and desires of our physician members.

This past year, the MSNJ Annual Meeting began an evolution with the introduction of *Physicians Conference 2000*. This gathering of specialty societies with MSNJ for educational and social purposes is a throwback to a past tradition. Looking forward, the evolution continues next year with a new House of Delegates format, largely spurred by the conference's success and the opportunities it presents to physicians.

Rather than meeting on three consecutive days in Atlantic City, the house will first convene on March 31 at a facility in the greater Princeton area for the opening session and the reference committees. During that next week, MSNJ staff will compile and distribute the committee reports to delegates. Because of the religious holidays falling on successive weekends, the house will then reconvene on April 19 in Atlantic City for the second and third sessions. *Physicians Conference 2001* then runs from April 20 through 22.

Delegates, county presidents, and the MSNJ Board of Trustees all strongly support the new format, which should provide numerous benefits, including the following:

- There will be sufficient time for county delegations to review the reference committee reports and to develop their strategies.
- Delegates may take full advantage of educational, political, and social sessions and other features of *Physicians Conference 2001*.

- Delegates can attend the house and the *Physicians Conference 2001* meetings without incurring additional time away from practices or expenses.
- MSNJ can realize significant cost savings.

The proposal to split the format in this manner was presented to delegates, along with other questions, in a survey conducted in late May. A response rate of more than 50% provided excellent feedback on the combined annual meeting and the *Physicians Conference 2000*.

Regarding the split format, more than 75% of responding delegates approved of the proposal and indicated that it would allow them to fully participate in the various conference activities. The positive word-of-mouth feedback from the 84% that registered for the first conference must have reached other delegates, as 93% said they plan to attend next year's event.

The new House of Delegates format and the introduction of *Physicians Conference 2001* illustrate how MSNJ is responding directly to the wishes of its physician members.

Next year, start your own tradition along with hundreds of other MSNJ members. Plan to attend the *Physicians Conference 2001* from April 20 through 22, or come a day early to watch your House of Delegates shape the course for continued advocacy on physician and patient rights.

**Joseph H. Reichman, MD, Donald J. Holtzman, MD,**  
**Chair Chair**

**Physicians Conference MSNJ Committee on**  
**2001 Task Force Annual Meeting**



# Senate Candidates Answer Health Care Questions

THE CAMPAIGN FOR THE US SENATE SEAT BEING VACATED BY RETIRING SEN. FRANK LAUTENBERG IS UNDER WAY. TO PROVIDE MEANINGFUL INFORMATION FOR OUR READERS REGARDING THE CANDIDATES' POSITIONS ON ISSUES RELATED TO MEDICAL CARE, NEW JERSEY MEDICINE SUBMITTED A LIST OF QUESTIONS TO REPUBLICAN CANDIDATE CONGRESSMAN BOB FRANKS AND DEMOCRATIC CANDIDATE JON CORZINE. ASSOCIATE EDITOR CLARK MARTIN, WHO COORDINATED THE EFFORT, PREPARED THE QUESTIONS.

**NJM:** What do you feel are the main issues facing health care and medicine today?

**Franks:** The nation's policy makers must restore to physicians and their patients the prerogative to choose appropriate treatments. We must empower physicians and patients to make decisions that are best for their situation.

**Corzine:** I believe the main issues facing health care and medicine are ensuring the passage of a strong Patients Bill of Rights, including the right to sue; the 44 million people without health care coverage, including 11 million children; the increasing cost of prescription drugs, which is hurting senior citizens who on average spend more on prescription drugs than younger citizens; and saving and strengthening Medicare as the trust fund faces unprecedented demands in coming years.

**NJM:** Do you believe that managed care plans, insurance carriers, and the federal government have too much involvement or not enough involvement in health care decisions today? What is the proper role of a physician in making health care decisions?

**Franks:** Currently, physicians and patients are largely powerless in making health care decisions. Physicians need to be in control of health care decisions, and until we change the federal laws governing the insurance industry, this goal will be unattainable.

**Corzine:** Physicians receive extensive education and training to prepare them to make clinical decisions on behalf of their patients. Physicians, not insurance companies, make the best health care decisions. A strong Patients Bill of Rights is the best single measure that will ensure that doctors and patients make health care decisions in the best interest of the patient, without interference from insurance company administrators and their accountants.

**NJM:** Would you support legislative efforts to ensure patient protections in the managed care industry? Do you support the Norwood-Dingell bill as passed by the House of Representatives last summer?

**Franks:** Yes. For the vast majority of Americans who receive their health insurance coverage through their employer, there is little protection from abusive or unfair practices by HMOs. To address this problem, I cosponsored the Norwood-Dingell Patients Bill of Rights (HR 2723) and voted in favor of this proposal when it passed the House last year. This legislation will help ensure that Americans will receive the best medical care available when they need it the most.

In an effort to empower patients and doctors, the Norwood-Dingell bill will allow a patient to sue an HMO; guarantee access to emergency room care; guarantee the right to appeal a denial of coverage; guarantee the right to an independent appeal for denial of coverage; guarantee access to specialists; and abolish all "gag rules."

**NJM:** What is your opinion on a patient's right to sue if denied care or coverage by their HMO?

**Franks:** If a patient is irresponsibly denied appropriate care by a plan and suffers negative health consequences, the HMO must be held liable for its actions. Patients (or when applicable, their estates) should have the right to sue when an insurer makes a decision that causes injury or wrongful death.

**Corzine:** As a senator I will fight to see that a strong Patients Bill of Rights is passed, covering all private health care plans. The Norwood-Dingell bill passed by the House in October was a victory for every family in every health plan. I would like to see the Senate pass that bill, and not the weak bill passed by Senate Republicans last year that amounted to an empty promise to the American people, handing to the insurance industry its own version of HMO reform.

**Corzine:** I will support a Patients Bill of Rights that provides the right to bring lawsuits when patients are denied benefits and to hold health care plans accountable for decisions that harm patients.

**NJM:** In today's health care system, who do you think should have more control over your health care decisions and treatment options, your physician or HMOs?

**Franks:** Clearly, we need to put *physicians* back in charge of medical decisions and hold insurance companies accountable for ensuring quality care for all their customers. Doctors owe their patients the benefit of their education, their experience, and their good judgment. By putting physicians back in charge of health care decisions, they and their patients will be able to freely communicate and together decide the best course of treatment.

**Corzine:** Medical professionals, not insurance company bureaucrats, should make decisions on health care. I will support a Patients Bill of Rights that includes a provision for independent external review of a denial-of-treatment decision.

**NJM:** Do you support professional liability reform? Would you support a \$250,000 cap on noneconomic damages?

**Franks:** Frivolous lawsuits and defensive medicine continue to drive up health care costs for all Americans. This is inexcusable, particularly at a time when Congress is searching for ways to control health care costs. Because serious medical malpractice reform should be enacted, I have supported legislation that places a \$250,000 cap on noneconomic damages.

**Corzine:** I would support only professional liability reforms that ensure that the rights of victims are fully protected.



**NJM:** Do you feel that medical professional organizations and consumer groups should be involved in Medicare reform? Do you have any specific ideas on Medicare reform? Please specify.

**Franks:** Our country must begin a national debate to reform the 35-year-old program called Medicare. As Congress debates Medicare reform, it's *essential* to involve both provider and patient advocate groups. The way in which health care is delivered in this country has changed dramatically since the creation of Medicare. Congress must now act to ensure that the health care system for our nation's seniors is as effective and generous as possible.

I look forward to this important national debate and support efforts that move Medicare away from a one-size-fits-all government-run program and closer to the health care program that members of Congress and other federal employees enjoy today.

**NJM:** Would you support antitrust relief allowing physicians to collectively negotiate with health plans, as provided in HR 1304, the Quality Health Care Coalition Act of 1999?

**Franks:** Yes. To address the abusive practices of HMOs and other managed care providers, I cosponsored and voted in favor of HR 1304. This legislation would allow health care providers—physicians, nurses, dentists, and pharmacists—to present a united front when negotiating the terms and conditions of a contract with health insurers. In my judgment, it is vital that medical professionals be allowed to form their own professional associations and bargain with insurers in a manner that will allow them to develop the best terms for their contracts and the highest quality of care for their patients.

**NJM:** Who or what do you feel is primarily responsible for the waste, fraud, and abuse in the health care system today?

**Franks:** Waste, fraud, and abuse are the work of a small percentage of people in every sector of the health care industry. As Congress seeks to eliminate wasteful spending, it must not punish the innocent in its pursuit of the few bad actors.

**Corzine:** I believe that both medical professional organizations and consumer groups should play a major role in the debate over Medicare reform. I support extending the solvency of Medicare by dedicating a portion of the non-Social Security surplus to the trust fund and adding a prescription drug benefit to Medicare. Americans between the ages of 55 and 65 should be able to buy into Medicare in order to receive health coverage at a reasonable price.

**Corzine:** Physicians are increasingly frustrated with managed care practices that threaten their control over clinical and business decisions. A strong Patients Bill of Rights is one way to reestablish the physician-patient relationship. Passing a strong Patients Bill of Rights will be a priority in the Senate, but that is not enough. I will support legislation that gives health care professionals the freedom to collectively bargain with HMOs.

**Corzine:** Schemes for fraud and abuse take many different forms, with different levels of detection, so it is difficult to say exactly who is primarily responsible. While I understand that it is important not to unduly penalize innocent mistakes, I will work to stop the practices of the small number of bad apples that engage in overbilling, charging for phony procedures, and selling substandard supplies. I will support efforts to combat this waste through increased law enforcement against companies and individuals engaging in health care fraud and increasing and better targeting audits and reviews to detect mispayments.

**NJM: Do you support the use of medical savings accounts (MSAs)? Please explain.**

**Franks:** In 1996, I supported legislation creating the first MSAs. MSAs are crafted to return power over health care choices to consumers and are a step in the right direction.

**Corzine:** I have concerns about the Republican-led proposals to expand MSAs. MSAs are used in conjunction with high deductible insurance policies, which means enrollees face high out-of-pocket costs if they get sick, especially if they have not had enough time to build up a balance in their account. Also, by attracting primarily healthy people to enroll into MSAs, sicker people could be left behind as the premiums on traditional low-deductible plans increase.

**NJM: Would you support a proposal to allow Medicare beneficiaries to privately contract with physicians for services already covered by the Medicare program?**

**Franks:** I would consider supporting such a proposal, provided that adequate protections were provided to prevent double billing of patients and Medicare.

**Corzine:** Under the current law, Medicare beneficiaries are allowed to privately contract with physicians for services. When Medicare already covers the services under the private contract, however, a number of important antifraud measures are required. I support the continuation of those requirements as a way to protect the patient and prevent Medicare fraud.

**NJM: Do you have physician involvement in your campaign? Please specify.**

**Franks:** Yes. I rely on the support, counsel, and guidance of a group of New Jersey physicians who have joined to form Physicians for Franks. During my successful primary campaign, more than 1,000 physicians from across New Jersey were active on my behalf.

**Corzine:** I have established a health care advisory committee with members from all parts of the health care profession, including a number of physicians. The mission of the committee is to ensure that I am well briefed on the concerns of the medical community and for input into my own proposals. I would like to extend the invitation to join the committee to those of you in the profession interested in helping my campaign for the US Senate.



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# The Prompt-Pay Law and Other Issues

*Assemblyman Nicholas Asselta*

For consumers, there is nothing more frustrating and disheartening than spending countless hours filling out insurance claim paperwork only to find out months later that because of a clerical error the insurance company is denying your claim and you will incur thousands of dollars in medical bills. I know that as medical professionals you sympathize with your patients who face these types of situations and are torn between wanting to provide quality care to your patients and facing the prospect of losing money in the process.

This is why I take great strides to help the people of New Jersey receive the quality health care they deserve and to help our medical professionals provide the kind of health care they have been trained to provide, without being held hostage by insurance companies.

I am proud to have introduced and sponsored a measure that was signed into law ensuring prompt payment from health insurance carriers to physicians and hospitals. Nicknamed the prompt-pay law, now pamphlet law Chapter 155, it forces health and dental insurance companies to pay both electronic and manual claims promptly following the receipt of the claims.

In an effort to hold insurance companies responsible, I also sponsored A-1656, the measure designated as the Health and Dental Care Claims Payment Responsibility Act, which forces insurers to reimburse the funds health care providers are entitled to for services delivered. The bill will force insurers to make the decision to either approve or deny a claim within a set amount of time following the claim being made. The exact time frame is still under consideration. This bill would put an end to the backup caused by claims pending decisions. The General Assembly Banking and Insurance Committee is currently considering this bill.

Another bill I introduced, which is currently being considered by the Assembly Health Committee, is A-2241, entitled the Health Care Provider Joint Negotiation Act. This bill, which was modeled after a similar bill in the Pennsylvania Senate, would permit independent physicians and other health care providers to engage in joint negotiations regarding the terms and conditions of their contracts with health insurance carriers.

The Health Care Provider Joint Negotiation Act would allow physicians to jointly negotiate with carriers on many nonfee-related matters that affect patient care. Some of these issues include utilization management criteria, preventive care and other medical management policies, critical practice guidelines, and patient referral standards and procedures, including but not limited to those applicable to out-of-network referrals.

As a New Jersey state assemblyman, I have had the opportunity to travel around my district and the entire state, talking to people about the problems they've experienced in dealing with their health and dental insurance companies. I have also received countless phone calls on the same topic. In addition, I have spoken to physicians and dentists and heard their dilemmas regarding the insurance companies as well. I can say with certainty that New Jersey's residents, doctors, and dentists are not getting a fair shake from insurance companies.

One phone call that stands out in my mind was from a man in his 40s who, after being recently diagnosed with bladder cancer, was for the first time dealing with the medical claims process of his health insurance company. In addition to worrying about how he would support his family while he is out of work and concentrating on his recovery from this horrible illness, should he have to deal with his insurance company delaying the approval of his claim and in turn his treatment process? Absolutely not!

I know that as medical professionals, you provide quality care to your patients with the understanding that you will be paid by their insurance companies in a timely fashion. You treat us when we need medical attention. Not when it's convenient for you. HMOs and health insurance carriers should be held to the same standard when it comes to paying their outstanding bills.

I know you agree that your top priority, as New Jersey's medical professionals, should be to provide quality patient care—not to answer to some HMO that is only concerned with its bottom line.

*Nicholas Asselta is an assemblyman from the first legislative district, which includes Cape May and parts of Cumberland and Atlantic counties. He also is vice chair of the Commerce, Tourism, Gaming, and Military and Veterans' Affairs and State Government committees.*



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# With All Deliberate Speed: Results of the First New Jersey Physician Prompt-Pay Survey

MSNJ STAFF SURVEYED PHYSICIAN PRACTICES TO IDENTIFY PREVAILING PATTERNS IN THE TIMELINESS OF CLAIM PROCESSING BY HEALTH MAINTENANCE ORGANIZATIONS IN THE STATE JUST BEFORE IMPLEMENTATION OF NEW PROMPT-PAY LEGISLATION.

*Steven Nash, Karen Guozzo, and Neil E. Weisfeld*

As evidenced by a large number of complaints received by MSNJ from its physicians and by coverage in both the news media and industry press, "prompt pay" by health maintenance organizations (HMOs) and other health insurance carriers has emerged as a leading controversy surrounding the impact of managed care on the practice of medicine.<sup>1,2</sup> To better understand the scope of the problem, MSNJ recently conducted a payment-timeliness survey.

Designed to gain an empirical, evidence-based understanding of how promptly health plans reimburse "clean" (i.e., complete and error-free) claims, the survey generated information about the length of time it takes health insurers to pay physicians for rendering health services to subscribers. The survey further elicited information about other aspects of the claims submission experience.

## BACKGROUND

With New Jersey's prompt-pay legislation taking effect on December 28, 1999, execution of the MSNJ survey became especially pertinent because it provides statistically significant baseline data for evaluating the impact of the legislation.<sup>3,4</sup> Before the survey, most information was anecdotal and thus limited in its effectiveness in influencing opinion on the prompt-pay debate.

The MSNJ survey was related to a larger, nationwide effort coordinated by the AMA. The AMA's Advocacy

Resource Center Payment Timeliness Survey Template served as the model for the survey, which MSNJ staff modified to incorporate additional questions reflecting the nuances of the New Jersey HMO market. The modified version was then pretested by members of the New Jersey chapter of the Medical Group Managers Association, who assisted in developing the final survey instrument.

After the survey period, the New Jersey Department of Banking & Insurance proposed regulations to implement the 1999 legislation and set up a dispute resolution mechanism.<sup>5</sup> Under the legislation and proposed regulations, carriers face a 30-day limit for processing electronically submitted claims and a 40-day limit for processing claims submitted manually. By contrast, Medicare claims generally require payment within 30 days, with 7% interest due thereafter.<sup>6</sup> At the time of the survey, HMOs in New Jersey were required to pay clean claims within 60 days or else furnish interest calculated at a 10% annual rate.<sup>7</sup>

The First New Jersey Physician Prompt-Pay Survey offers baseline data on the leading HMOs' performance in paying claims on a timely basis. When assessing the results, readers are asked to bear in mind that a 60-day limit was in effect at the time but was about to be supplanted by the 30- and 40-day limits.

## METHODOLOGY

The MSNJ survey asked the respondent practices to indicate, for each of the HMOs listed, how many days typ-



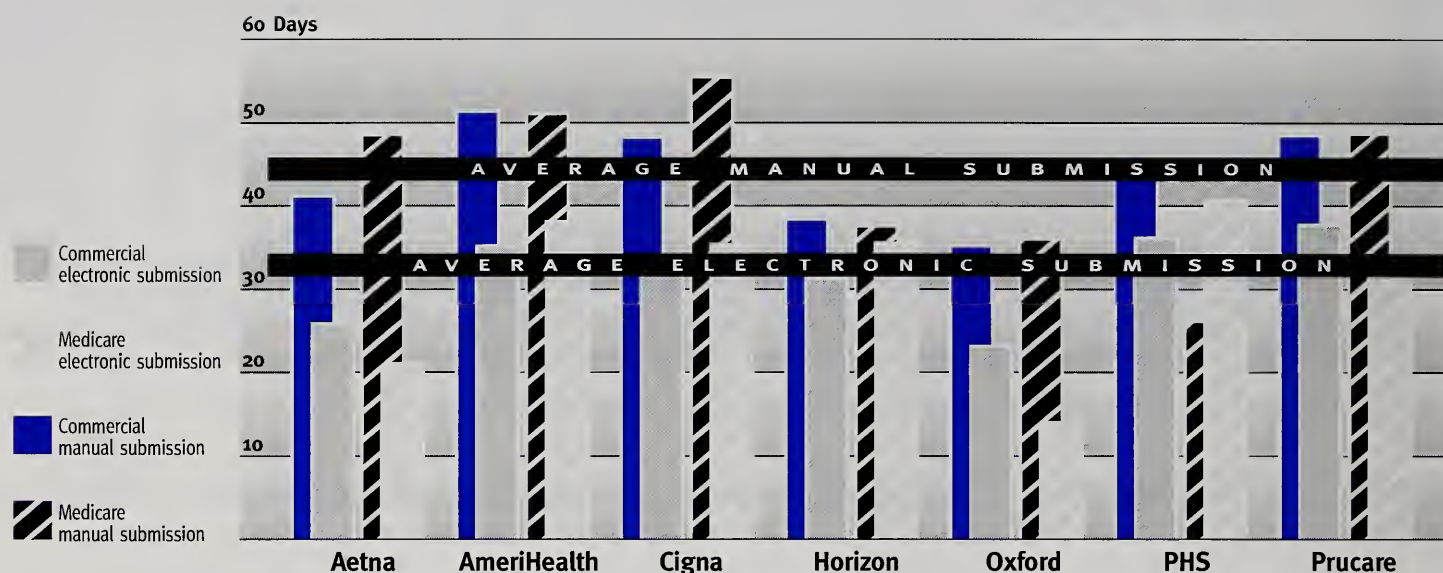


Figure 1. Weighted Average Number of Days to Payment of Clean Claim.

ically passed from bill submission to receipt of payment for clean claims submitted during the six-month period from January 1, 1999, through June 30, 1999. In addition, the survey included questions relating to the number of physicians in the practice, the number of patients in the practice, and whether the practice billed electronically for each of the health insurers.

The prompt-pay survey was conducted in two waves, with distributions in October and December 1999. Random samples were generated based on members' medical education numbers and resulted in a total sample size of 3,693.

Recipients were asked to forward the survey to the person in their office who handles insurance claims and billing services. These individuals, in turn, were advised to review their current billing records before completing the survey and to answer questions only for those carriers with which they had experience. The survey listed seven carriers, who in aggregate commanded an 89.6% market share of the total HMO business in New Jersey in 1999.<sup>8</sup>

The survey instrument also allowed for inclusion of data on other health insurers, and respondents provided information about seven additional plans. However, this information was deemed statistically insufficient and therefore was not included in the analysis.

For each of the seven carriers listed on the survey instrument, the survey asked respondents to provide

separate data for commercial (i.e., non-Medicare, non-Medicaid) and Medicare HMO products. Inclusion of two distinct product lines allowed for inferences about the extent of claims processing problems—that is, the data would reveal if payment delays were product-specific or systemic in nature.

MSNJ received a total of 73 responses from medical practices throughout New Jersey. Respondents appear highly diverse in terms of practice size and specialty and geographic distribution. Twenty-five responses were eliminated from the final analysis due to insufficient or invalid data. Therefore, the analysis was based on data from 48 practices, which represented 179 physicians and more than 550,000 patients. According to the survey data, more than 150,000 claims were submitted by these practices during the six-month survey period.

Averages were compiled in two ways. "Means" presented in the results are averages per respondent. "Weighted" means or averages presented in the results are averages per claim as a result of factoring in the number of claims submitted by each respondent.

## RESULTS

The survey disclosed the general perception of physician practices that the turnaround time for payment by HMOs has not improved despite reform efforts. An overwhelming 83% of respondents indicated that pro-

cessing delays recently have either worsened or not improved. In addition, as evidenced by mean and weighted-mean payment delays (43 and 37 days, respectively), a practice's extensive experience with a particular health insurer only minimally improves turnaround time. (In other words, a practice isn't likely to "learn" how to improve an HMO's responsiveness, and HMOs don't expedite processing for practices that have proved loyal to the HMO.)

Furthermore, the survey found that, regardless of the method used to determine the average turnaround time, HMOs in New Jersey delayed payments to physicians beyond statutory limits now in place. Most respondent practices experienced mean processing times of greater than 30 days, ranging from a high of 60 days for one HMO to a low of 32 days for another HMO.

Data was also collected on the method of claims submission. Analysis reveals that, for all but one of the listed carriers, electronic claims submission shortened processing times. The weighted mean processing period across all carriers was 31 days for electronic claims submission and 44 days for manual submission. The period for electronic submission ranged from a high of 41 days to a low of 15 days; for manual submission the range was from a high of 54 days to a low of 27 days (see Figure 1).

However, for both electronic and manual claims submission the average payment lag exceeded the new statutory requirements of 30 and 40 days, respectively, that became effective after the survey period. In fact, 35% of the physician practices that responded experienced payment delays across all HMOs of greater than 30 days when filing electronically while 50% of those who filed manually were paid within the time frame stipulated under the new prompt-pay law (see Figure 2).

An average of only 13% of respondents reported that they received interest on late payments across all HMOs (see Figure 3). Rates were low for all carriers except Oxford.

Analysis shows that an average of approximately 70% of those claims filed by the survey respondents were found by HMOs upon initial receipt to be clean, ranging from a high of 89% clean for Prudential Health Care commercial to a low of 59% clean for AmeriHealth commercial. The remaining claims were classified as containing some sort of error that prevented them from being considered clean and therefore resulted in a processing delay.

The survey asked recipients to designate the primary error reasons given by HMOs for these processing delays. Respondents indicated that lack of preauthorization of service ranked as the most prevalent reason for delay, followed by claims not received or lost, addi-

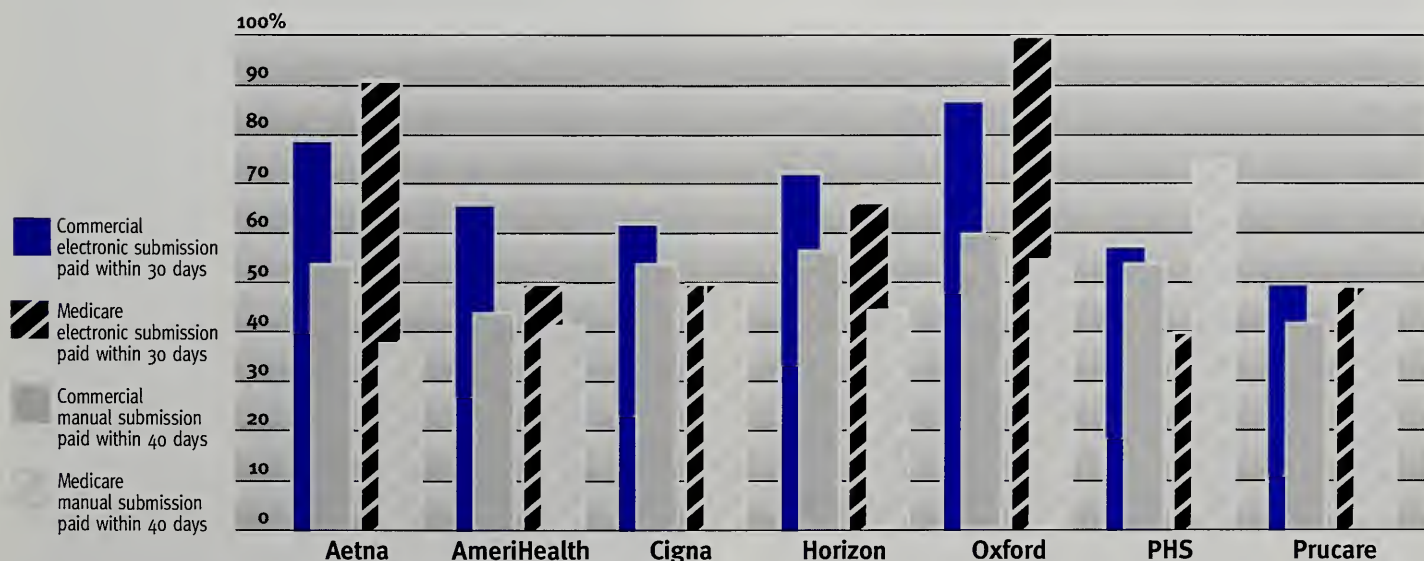


Figure 2. Percentage of Respondents Receiving Payment within 30 Days (for electronic submissions) or 40 Days (for manual submissions).



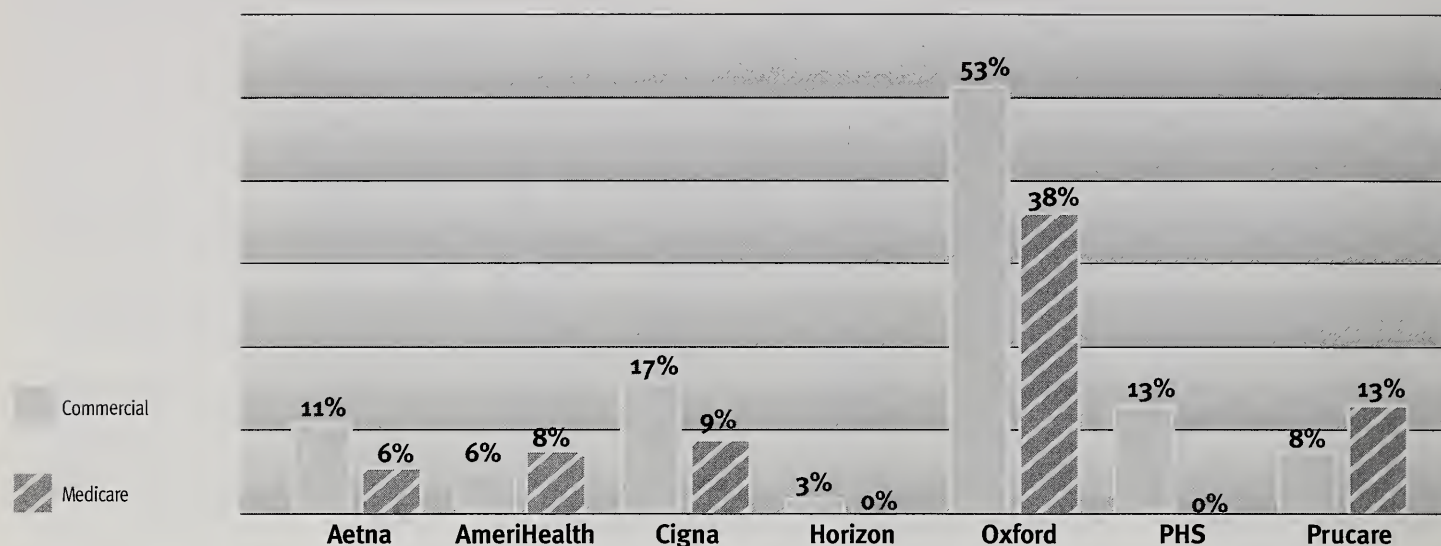


Figure 3. Practices Receiving Interest on Late Payments.

tional documentation required, and claims pending for additional review.

The survey reveals that these errors or determinations resulted in significant processing delays. Typically, a practice resubmits the claim after correcting any obvious deficiencies. For purposes of this survey, we term these resubmissions "appeals." The mean processing delay following an appeal across all HMOs was 74 days. The weighted mean processing delay following appeal was 73 days. This narrow differential again suggests that extensive experience with any particular HMO had no significant impact on reducing the processing time.

## DISCUSSION

As reported here, even with a relatively small number of usable responses, the First New Jersey Physician Prompt-Pay Survey reveals serious challenges for payors in complying with the new statutory time frames, for physicians attempting to survive in an unforgiving and sometimes unresponsive market, and for regulators beginning to design an enforcement strategy for the new prompt-pay provisions.

It is especially troubling that 83% of respondents perceive that delays have not improved under regulatory control. State officials in Trenton have struggled with prompt-pay issues at least since 1996, when they persuaded all members of the state HMO association to sign an agreement to pay claims within 60 days.

Additionally troubling is the HMOs' nearly universal resistance to making interest payments, despite their voluntary pledges and subsequent regulatory requirements. If the new laws are to be taken seriously, the authorities first may need to establish their credibility by enforcing the interest-payment strictures. One caveat to the interest concerns: New Jersey interest requirements may not apply to Medicare products.

Mere blaming of HMOs will not resolve difficulties for physician practices. Only 70% of claims are classified as clean, which raises the possibilities of poor claim submission procedures or miscommunication between HMOs and the practices. Although the survey instrument did not address practices' delays in submissions or the role of claim vendors who process claims for practices and then submit the claims to the HMOs, these areas have been the subject of complaints voiced anecdotally by HMO executives and medical directors (see sidebar).

Insurance industry critics of physicians may argue that claims processing is a contractual matter between physicians and carriers that has no bearing on patient care. But patient care is involved to the extent that employers and others purchase health insurance and patients present health insurance cards to physician practices in the expectation that the insurer will pay claims properly on the patient's behalf.

Equally troubling from a public policy perspective is a lesson from New Jersey's unfortunate experience in 1998 with the ill-fated HMOs of HIP and the American Preferred Provider Plan (APPP). Both HMOs went bankrupt, leaving approximately \$150 million in unpaid claims and jeopardizing enrollees' access to health care. The HIP-APPP experience demonstrated that claims processing delays are an early warning of an HMO's financial weakness and possible collapse.

Oxford Health Plans performed relatively well during the survey period in diverse domains. Areas of comparative achievement include weighted average number of days to payment (Oxford commercial and Medicare), payment of interest (Oxford commercial and Medicare), payment of electronic claims within the new statutory limit (Oxford Medicare), and practices' perceptions of payment trends (Oxford commercial). Whether this strong performance persisted through late 1999 and continues to persist through 2000 is not yet clear.

### One County's Experience

The Atlantic County Medical Society, a component of MSNJ, conducted a focused study of its members' HMO-related complaints in the spring of 2000. Most of the complaints, all reported confidentially, involved two carriers, AmeriHealth and Horizon.

For AmeriHealth, 19 of the 76 complaints, an even one-fourth, involved payment delays. Other leading causes of complaints were denials (16) and failures to pay according to the agreed fee schedule (11). AmeriHealth physicians also said they encountered difficulty in obtaining preauthorizations, inappropriate bundling of procedures for payment purposes, and down-coding of procedures.

For Horizon, denials accounted for seven of the 28 complaints (one-fourth). Delays were cited in five complaints (18%).

These results suggest that, even after fixing their prompt-payment problems, HMOs still will have plenty of room for improvement in the eyes of the state's physicians.

### AETNA RESPONDS

*Asked to comment briefly on the survey results pertaining to its own performance, Aetna US Healthcare's regional office furnished the following statement:*

While we are concerned that the time frames and other criteria used as benchmarks differ from the state requirements, we are nevertheless pleased that the results seem to reflect our internal finding that our electronic claims initiative is taking hold and creating efficiencies. Our standard for payment of claims submitted electronically is 15 days or fewer. Regionwide, our average claims turnaround time for manually filed claims is fewer than 20 days.

*Aetna is the state's largest HMO. The other six HMOs included in the survey did not accept MSNJ's repeated invitations to comment.*

Other relatively high scores in the same domains include Aetna Medicare for payment of electronic claims within the new statutory limit, PHS Medicare for payment of manual claims within the new statutory limit, and Aetna and Prudential Medicare for weighted average number of days to payment.

Low scores in these domains abound and are shared by several HMOs. Prudential and PHS Medicare scored low in payment of electronic claims within the new statutory limits. Aetna Medicare and AmeriHealth did not perform well in payment of manual claims within the new statutory limits.

In the area of weighted average number of days to payment, CIGNA, Prudential commercial, AmeriHealth, and Horizon Medicare all show a significant need for improvement.

None of the following commercial HMOs appears to be complying substantially with interest-payment requirements: Horizon, AmeriHealth, and Prudential. AmeriHealth also is perceived by practices as showing unfavorable trends and fails to attract electronic claims.

### CONCLUSION

Because this first survey was intended principally to establish baseline data, no inferences reasonably can be



### *It's not just the insurance companies . . .*

In the brave new world of managed care, multiple hands touch hard-copy claims and transmit electronic claims before HMOs and other insurance carriers ever receive them.

Intermediaries between physicians' offices and carriers include billing agencies that prepare claims, vendors that fit claims into formats that meet the specifications of individual carriers, and administrative entities that review claims on carriers' behalf.

At any of these steps along the way, a claim might be "down-coded" or rejected.

In addition, even before leaving the physician's office, a claim might be compromised if the physician's office staff failed to secure a proper authorization, accurately complete all blocks of the claim form, or ensure compliance with coding rules.

To maximize payment and minimize problems, physicians can take the following measures, among others:

- Hire a qualified practice manager and other staff (these are important jobs).
- Obtain a competent review of the HMO's provider contract before signing.
- Personally review coding rules for frequently performed procedures.
- Apply current procedural and diagnostic coding information.
- Make sure that vendors return or supply feedback on all rejected claims to help the physician's office staff to track these claims and avoid future errors.
- Establish a compliance program to immunize the practice from accusations of fraud.
- Demand and review summaries of outstanding claims on at least a monthly basis to identify persistent problems.
- Submit complaints and appeals as appropriate to protect the practice and patients.

Resources available to help in these efforts include the MIIX Health Care Group's Policies & Procedures Manual, information disseminated routinely by MSNJ as well as MSNJ's complaint system, and the Medical Group Managers Association. MSNJ also is creating a practice managers section to strengthen physicians' office staffs. And the AMA has developed a Revised Model Managed Care Medical Service Agreement.

drawn from it about the impact of the state's new prompt-pay laws. Subsequent surveys may reveal dramatic improvements in performance. If performance does not improve, however, the medical community almost surely will feel justified in demanding extremely rigorous enforcement actions. Widespread noncompliance with popularly enacted laws suggests a failure of both regulatory and market systems.

### ACKNOWLEDGEMENTS

The authors extend appreciation to the AMA, and in particular to Matthew Katz of the AMA staff, for essential assistance in this project. The help of the New Jersey chapter of the Medical Group Managers Association also is gratefully acknowledged.

*Steven Nash is manager of information systems, Karen Guozzo is administrative assistant, and Neil E. Weisfeld is deputy executive director of MSNJ in Lawrenceville.*

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# Anthrax

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## An Old Disease Returns as a Bioterrorism Weapon

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Maria Falca Morgan, BSN, MA

**A**nthrax, an exotic disease rare in the United States today, has captured headlines because it has been used in threats of bioterrorism. In 1999, because of the potential use of anthrax in biological warfare and bioterrorism, the federal Department of Defense (DoD) required all military personnel to be immunized. This order prompted questions about the safety, efficacy, and side effects of the vaccine, which some military personnel refused to receive. This article discusses the natural history of the disease, anthrax as a bioterrorist weapon, and the safety of the vaccine.

### MICROBIOLOGY

Anthrax, caused by *Bacillus anthracis*, is an aerobic, gram-positive, spore-forming, nonmotile member of the *Bacillus* species. The three clinical forms depend on the mode of transmission or exposure.

*Cutaneous anthrax* occurs after the exposure of an open wound to spores. The first symptom, which usually occurs within a half day to five days postexposure, is usually a papule with swelling. The papule ruptures after one week, leaving an ulcer or blackened eschar—hence the name *anthrax*, which is Greek for coal. If the disease is untreated the mortality rate is 5% to 20%. If treated, there is less than 1% mortality.<sup>1</sup>

*Gastrointestinal anthrax* is extremely rare and occurs two to five days after the ingestion of contaminated meat. Symptoms include watery diarrhea, gastrointestinal bleeding, and abdominal pain. The mortality rate is more than 50% because of difficulty with differential diagnosis. In fact, the diagnosis is usually made by postmortem examination.<sup>1</sup>

*Inhalational anthrax* has an incubation period from one to six days, with an average of three days.

Clinical presentation has been described as a two-stage illness. Patients first develop a spectrum of nonspecific symptoms such as fever, cough, headache, dyspnea, vomiting, chills, abdominal pain, chest pain, and malaise, which then resolve for a brief period. Laboratory studies are usually nonspecific. This is followed by the abrupt onset of sudden fever, dyspnea, diaphoresis, respiratory failure, shock, and death. Mortality is 100% if no intensive care is received. Even with intensive treatment, mortality remains 80%. The mortality rate of occupationally acquired cases in the US is 89%, but the majority of cases occurred before the development of critical care units and, in some cases, before the advent of antibiotics.<sup>2</sup>

Treatment consists of antibiotics that are specific to the type of anthrax. Effective antibiotics include penicillin, ciprofloxacin, or



doxycycline, coupled with respiratory support. There are no clinical studies of the treatment of inhalational anthrax in humans. Animal models (a small number of monkeys infected with susceptible strains of *B anthracis*) demonstrate that doxycycline is the preferred option, but studies with ciprofloxacin also suggest excellent efficacy.<sup>2</sup> The correct treatment is based on the response of the disease and, for a given individual, can only be known in retrospect.<sup>2</sup> Laboratory confirmation consists of the demonstration of the causative organism in blood, lesions, or discharges by direct polychrome methylene blue (M'Fadyean)-stained smears or by culture or inoculation of mice, guinea pigs, or rabbits.<sup>3</sup> Testing is provided by the New Jersey Department of Health and Senior Services certified state laboratory.

Inhalation anthrax is not spread by human-to-human contact, presumably because the bacteria move into the lymphatic system and do not stay in the lungs where they could be spread through coughs of the infected person. The anthrax vaccine is intended to prevent inhalational anthrax primarily from aerosolized and dispersed spores.

## EFFECTIVE ANTIBIOTICS INCLUDE PENICILLIN, CIPROFLOXACIN, OR DOXYCYCLINE, COUPLED WITH RESPIRATORY SUPPORT.

### NATURAL HISTORY

Naturally occurring anthrax is acquired through contact with anthrax-infected animals or anthrax-contaminated animal products. The disease most commonly occurs in herbivores, which are infected by ingesting spores from the soil. Vaccination programs have dramatically reduced animal mortality from the disease. Anthrax spores continue to be documented in soil samples from throughout the world, however, and in countries where animals are not vaccinated, mainly Africa and Asia, the disease still occurs.<sup>4</sup> Recently, reports of gastrointestinal exposure have surfaced in South Korea, Romania, Ethiopia, and Kazakhstan. Public health reports continue to be routine regarding exposures.<sup>5</sup>

Annually, approximately 2,000 anthrax cases occur worldwide. Only 224 cases of cutaneous anthrax were

reported in the US from 1944 to 1994. Even rarer are human cases of the inhalation form. Only 18 were reported in the US during the 20th century.<sup>4</sup>

### ANTHRAX AS A BIOTERRORISM WEAPON

Research on anthrax as a biological weapon began more than 80 years ago. Anthrax was used by Germany against pack animals in World War I, by Japan against China in World War II, and in the Rhodesian civil war in 1978.<sup>1</sup> Today, at least 17 nations are believed to have offensive biological weapons programs and it is uncertain how many are working with anthrax. Iraq has acknowledged producing anthrax for use as a weapon.<sup>1</sup>

One terrorist group, Aum Shinrikyo, responsible for the release of sarin (a nerve agent) in a Tokyo subway in 1995, dispersed aerosols of anthrax and botulism throughout Tokyo on at least eight occasions. These attacks failed to produce illness.<sup>1</sup>

The lethal potential of anthrax was demonstrated by an accidental release of aerosolized anthrax spores from a military microbiology facility in Sverdlovsk in the then Soviet Union in 1979. At least 79 cases of

anthrax infection and 68 deaths occurred. Cases occurred from 2 to 43 days after exposure. Patients whose onset of disease occurred 30 or more days after release of organisms had a higher reported survival rate compared with those with earlier disease onset. In fatal cases, the interval between onset of symptoms and death averaged three days.<sup>2</sup>

For anthrax spores to be used as weapons they must be aerosolized and dispersed. It is difficult to place the medium into a delivery form but once aerosolized, it does not require a sophisticated delivery system. Spraying from an airplane or the back of a truck is sufficient. Russia has developed liquid and dry aerosolized spores.<sup>1</sup>

In 1970, the World Health Organization (WHO) estimated that casualties following the theoretical aircraft release of 50 kg of anthrax over a developed urban population of 5 million would be 250,000. Of these, 100,000 would be expected to die without treatment.<sup>1</sup> A 1993 report by the US Congressional Office of Technology Assessment estimated that between 130,000 and 3 million deaths could follow the aerosolized release of 100 kg of anthrax spores upwind of the

Washington DC area. An economic model developed by the Centers for Disease Control and Prevention (CDC) suggested a cost of \$26.2 billion per 100,000 persons exposed.<sup>1</sup>

## HISTORY, SAFETY, AND EFFICACY OF THE VACCINE

### Development

Pasteur, Toussaint, and Greenfield developed the first animal anthrax vaccines in 1880. In 1935, Sterne developed an attenuated live animal vaccine that is still used today. The human vaccine is an inactivated cell-free product originally developed by Merck and the CDC to protect textile mill workers during the 1950s. Brachman was the first to study the effectiveness of this vaccine in the mill workers from 1955 to 1959, and he published his results in 1962.<sup>6</sup> In the four-year

period there were 21 cases of cutaneous and 5 cases of inhalational anthrax reported. All of the cases of infection were either in the control group or in persons who had lapsed in their vaccine series or did not receive the vaccine at all.<sup>6</sup>

From 1966 to 1970, the CDC studied the efficacy of the vaccine on 7,000 textile and laboratory workers. No cases of anthrax were reported. By the 1960s the vaccine was manufactured by the Biologic Products Division of the Michigan Department of Public Health, which became Michigan Biologics Products Institute in 1996. In November 1970, the Food and Drug Administration (FDA) licensed the vaccine.<sup>7</sup>

From 1970 to 1989, 68,000 doses of vaccine were given. From 1962 to 1974, 27 cases of anthrax were reported to the CDC but none in fully vaccinated persons. In 1985 the anthrax vaccine was reviewed by an advisory review panel of the FDA and approved. In 1998 Michigan Biologics Products Institute was purchased by Michigan BioPort, which continues to be the sole manufacturer.<sup>7</sup> In February 1998, the FDA inspection report on the Michigan BioPort operation cited

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quality control failures in anthrax vaccine manufacture. BioPort continues to work under the close scrutiny of the FDA to correct all deficiencies.<sup>7</sup>

Concurrently, the FDA is revalidating and rechecking old vaccine for release and use. In addition, the FDA has threatened to revoke Michigan BioPort's manufacturing license, citing an inadequate response to previous concerns raised by the agency.

### Follow-up of Vaccinated Humans

Human clinical trials have not been performed, with the exception of retrospective analysis of exposures and occupational follow-up of vaccinated individuals. In 1962, Brachman studied 1,300 mill workers with an anthrax incidence of 1.2 cases per 100 employees. There were no cases of anthrax in the 793 people who completed the vaccine series. There were 26 cases of anthrax in individuals who had not completed the series, 21 due to cutaneous exposures and 5 inhalational in origin. Four of the five inhalational exposures died.<sup>6</sup>

The Report of the Working Group on Civilian Biodefense, which was developed through a consensus process, recommends spe-

## A 1993 REPORT ESTIMATED THAT BETWEEN 130,000 AND 3 MILLION DEATHS COULD FOLLOW THE AEROSOLIZED RELEASE OF 100 KG OF ANTHRAX SPORES.

cific therapy and postexposure prophylaxis. Most important, this report suggests the use of limited quantities of the vaccine in the civilian population.<sup>2</sup>

### Side Effects and Adverse Reactions

In Brachman's study, a mild local reaction was noted in 30% of doses administered, moderate reactions in 4%, and systemic in less than 0.2% of doses. At the US Army Medical Research Institute of Infectious Diseases (USAMRIID), testing of anthrax has been extensive. In 99 workers immunized there for a total of 1,590 doses over 25 years, only 4% had a mild local reaction and 0.04% had a systemic reaction. There have been no long-term illness reports related to the vaccine.<sup>7</sup>

A prospective study including 603 medical personnel is currently under way at the Tripler Army Medical Center (TAMC) in

Honolulu. In April 2000, reports from the CDC verified that systemic reactions were not remarkably different from previous clinical experience.<sup>8</sup> Local reaction rates were reported at higher levels in this study than previous research, but the subjects in the study were specifically questioned about these reactions. This design may support a higher reporting of mild reactions.

As of July 2000, more than 450,000 military members have been vaccinated with more than 1,800,000 doses of anthrax vaccine. There have been 443 anthrax-related reports on individuals to the Vaccine Adverse Event Reporting System (VAERS). A total of 319 were considered not serious, because they did not result in duty loss for more than 24 hours. Of the remaining 124 reports, 118 were not hospitalized and 6 were hospitalized.<sup>9</sup> Because of the military controversy, there is intense scrutiny by the DoD and Congress regarding the reaction rate.

### The Controversy in the Military

Current DoD requirements include a mandatory anthrax mass immunization program conducted in three phases, which applies to all

active, reserve, and National Guard components.<sup>10</sup>

The controversy in the military began in March 1999, with an article questioning vaccine safety and effectiveness by Meryl Nass in *Infectious Disease Clinics of North America*.<sup>7</sup> Following this, Dr. Nass testified before the Subcommittee on National Security, Veterans Affairs, and International Relations in April 1999, maintaining that intensive care and antibiotic therapy should be sufficient to manage exposures based on her assessment of the current risk of exposure.<sup>11</sup> Coupled with multiple infractions in the manufacturing process identified by the FDA at Michigan BioPort and the financial involvement of that firm with former Chairman of the Joint Chiefs of Staff Admiral William J. Crowe in July 1998, a conspiracy theory was born.

The conspiracy theory alleges that the content of the vaccine is different from that stated on the labels and package inserts. An article in May 1999 in *Vanity Fair* entitled "The Pentagon's Toxic Secret" further fueled this theory. The article contends that the vaccine contained a large amount of squalene (an adjuvant) in an attempt to develop a

more effective vaccine with fewer doses. The author asserts that the DoD tested a variation of the anthrax vaccine on Gulf War soldiers and this testing is linked to the etiology of Gulf War Syndrome.<sup>12</sup> The credibility of the article is strained, and it contains many inconsistencies.

Military personnel have been vaccinated in the United Kingdom and Canada, although both programs are voluntary. Recently the American Public Health Association issued a policy statement in support of a voluntary-only military program, largely because of the lack of documented efficacy and because of the voluntary UK program.<sup>13</sup>

Unsubstantiated anecdotal central nervous system symptoms such as vertigo have been reported, which have spurred the resistance to receiving the vaccine mostly among

THE CONTROVERSY IN  
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MERYL NASS.

aircrew in the Air Force, both active and reserve. Although none of these symptoms have been directly linked to the vaccine administration, pilots fear loss of their ability to fly. This is particularly so for reserve aircrew with civilian flying careers. It has been reported in the media that at least 300 military members refused vaccination and have had some type of subsequent disciplinary action. The DoD's initial response to questions about the vaccine order was to simply announce that the vaccine was a requirement and not receiving it would be grounds for discharge. Since that time, because of the large numbers of individuals in key specialty areas exiting the military on a voluntary basis because of the vaccine requirement, the DoD has launched a massive education program. Overall response to this education program has been mixed. The true impact cannot be assessed until the vaccine program is fully implemented. Because of vaccine supply shortages, the full implementation of the vaccine program has been delayed by the military. The shortage of vaccine supply has forced the Pentagon to assign priorities to inoculations and redistribute remaining vaccine.



## CONCLUSIONS

The use of anthrax as a biological weapon must be taken very seriously. The inhalation form of anthrax is easy and inexpensive to obtain, manufacture, and deploy. The disease is insidious and difficult to diagnose and treat, and the only protection is the vaccine.

The vaccine, although hindered by erratic development and testing, is now scrutinized by the FDA, which will closely monitor any newly manufactured vaccine. The reporting process for reactions is detailed and is receiving much attention from both sides of the controversy. The consensus report from the Working Group on Civilian Biodefense from the Johns Hopkins Center for Civilian Biodefense Studies recommends the use of vaccine. Neither the civilian nor the military medical systems would be able to respond appropriately to the needs of either population if exposure occurred. The availability of intensive care and antibiotics needed for adequate treatment could not meet the demand even if an accurate and timely diagnosis were made.

New Jersey is a densely populated state with multiple military installations, and physicians must be aware

## THE SHORTAGE OF VACCINE SUPPLY HAS FORCED THE PENTAGON TO ASSIGN PRIORITIES TO INOCULATIONS AND REDISTRIBUTE REMAINING VACCINE.

of the threat of anthrax. The CDC has given grants to 21 states, including New Jersey, to rebuild the public health infrastructure for identification and follow-up of exposures to certain biological agents, including anthrax. The Federal Bureau of Investigation, however, remains the lead agency in dealing with any threat or exposure. Physicians should become familiar with which agencies to notify if they come in contact with a threat, real or alleged, of exposure to anthrax.

## ACKNOWLEDGEMENTS

The author wishes to acknowledge the assistance and input of the following individuals who were invaluable in developing and editing this article: Aldo Baldi, MD, Larry Burris, DO, Matt Baker, PA-C, MS.

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## PROCEDURES FOR CONTACT WITH A PERCEIVED ANTHRAX THREAT OR SUSPECTED EXPOSURE

1. Anyone receiving a threat about dissemination of anthrax organisms should notify the local office of the FBI immediately. In the US, the FBI has primary responsibility for the investigation of such biological threats, and all other agencies are to cooperate and provide assistance. The Newark office of the FBI (1 Gateway Center, 22nd floor, Newark NJ 07102-9889, [973] 792-3000) handles all of New Jersey except for Camden, Gloucester, and Salem counties, which are handled by the Philadelphia office (8th floor, 600 Arch Street, Philadelphia PA 19106, [215] 418-4000).

2. The local health department and the New Jersey State Department of Health and Senior Services should be notified also for public health management.

3. Persons who may have been exposed to anthrax are not contagious, so quarantine is not appropriate.

4. Persons who may have been exposed should be advised to await lab results and need not be placed on chemoprophylaxis. If they become ill before lab results are available, they should immediately contact their local health department and proceed to a predetermined emergency care unit.

5. If the threat of exposure to aerosolized anthrax is credible or confirmed, persons at risk should begin postexposure prophylaxis with both an appropriate antibiotic and vaccine. Postexposure immunization with an inactivated, cell-free anthrax vaccine is indicated in conjunction with chemoprophylaxis following a proven biologic incident. Immunization is recommended because of the uncertainty of when or if inhaled spores may germinate. Postexposure immunization consists of three injections as soon as possible after exposure and at two and four weeks after exposure. This vaccine has not been evaluated for safety and efficacy in children younger than 18 years of age or adults 60 years of age or older.

6. All first responders should follow local protocols for incidents involving biological hazards.

7. Technical assistance can be provided immediately by contacting the National Response Center at (800) 424-8802 or the local weapons of mass destruction coordinator of the FBI.

From Chin J, ed. *Control of Communicable Diseases Manual*, Official Report of the American Public Health Association, 2000.



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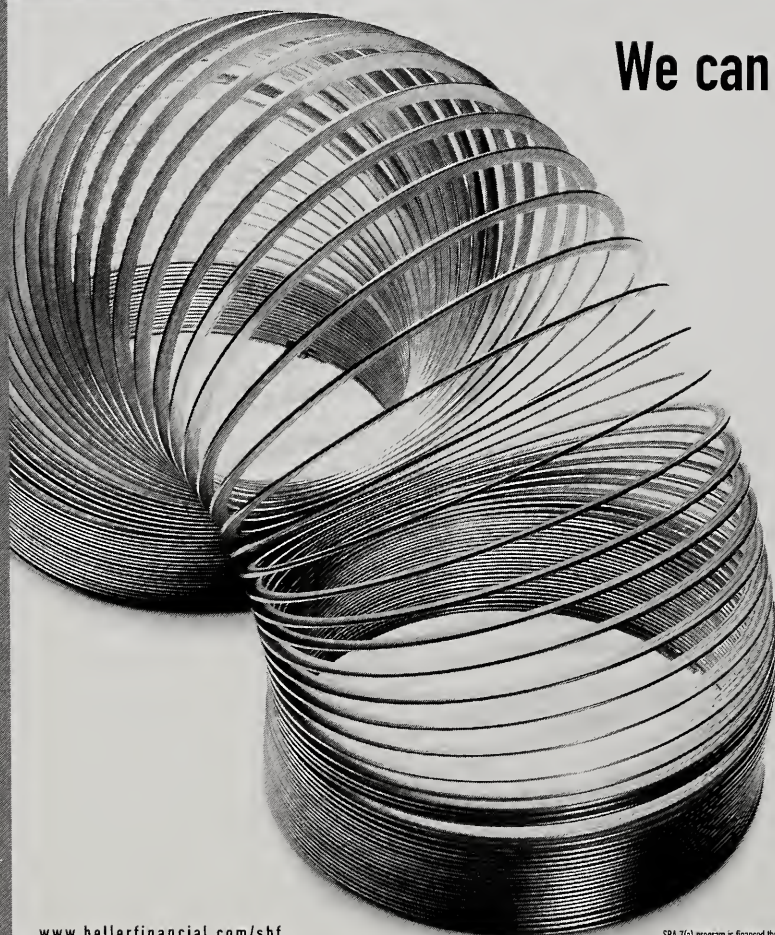


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# Avoiding the Hostile Work Environment

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*Steven I. Kern, Esq.*

Complaints of sexually or ethnically inappropriate comments or sexual-boundary violations by employees are likely to generate immediate investigation with devastating consequences. Managed care organizations, medical boards, employers, and hospitals are taking a zero-tolerance position with respect to this type of conduct. Most hospitals now have a "Disruptive Physician Policy," which provides hospital boards with broad authority to discipline a physician accused of being disruptive. Every large employer has a sexual harassment policy prohibiting any type of sexually offensive con-

duct. The law demands immediate investigation and action whenever a complaint of sexual harassment occurs.

Although most large employers have taken aggressive action to protect against sexual harassment and other improper conduct in the workplace, many small employers, including many physician practices, still lack essential workplace policies. Failure to maintain effective programs to protect against employee harassment is foolhardy. Huge punitive damages can be assessed against an employer, even if the employer is unaware of the conduct.

These awards are not covered by malpractice policies.

Even if written policies exist, a lack of effective implementation and continuous vigilance severely weakens the protections offered by these policies. An effective workplace behavior policy requires more than just a piece of paper. It must be aggressively implemented, regularly updated, and subjected to routine affirmative inquiry.

Moreover, many physicians and others are confused by the very meaning of the words "sexual harassment" and "disruptive physician." For example, a person can be found guilty of sexual harassment



even though there has been no sexual activity or even sexual comment. A person can be classified as a disruptive physician simply based on the subjective reaction of another.

This article is intended to help provide physicians with a clearer understanding of the minefield of what many view as today's hottest litigation area—the hostile work environment.

## WHAT IS A HOSTILE WORK ENVIRONMENT?

A hostile work environment is defined as any environment that creates an intimidating, hostile, or offensive working environment. It can occur in the office, the hospital, or the community. This definition is exceedingly broad. Like most broad definitions, it is subject to gross abuse, making it the perfect excuse for hospitals, managed care organizations, employers, and others to terminate or otherwise discipline a physician who is disliked for other reasons. Often, the reasons that lead to a physician being labeled disruptive have little to do with overt, wrongful conduct. Many times the real impetus behind the action is economic or competitive. For example, entrepreneurial physicians venturing out to start their own practice are far more likely to

find themselves charged with disruptive conduct by their former partners than are faithful employees, especially if the new practice provides a serious competitive threat to the former employer.

An even more fertile source of physician complaints originates with disgruntled employees seeking retaliation. A physician's innocent comments, which received no reaction from the employee during the employment tenure, can be taken out of context and radically twisted by a departed, vengeful employee. If three or four disgruntled employees gang up, they can literally destroy a physician's practice.

ALTHOUGH MOST LARGE EMPLOYERS HAVE TAKEN AGGRESSIVE ACTION TO PROTECT AGAINST SEXUAL HARASSMENT AND OTHER IMPROPER CONDUCT IN THE WORKPLACE, MANY SMALL EMPLOYERS, INCLUDING MANY PHYSICIAN PRACTICES, STILL LACK ESSENTIAL WORKPLACE POLICIES.

In these cases, an innocent hug suddenly becomes a "bear hug." Comments about dress or hairstyles become allegations that the physician was always making suggestive remarks about the employee's appearance. Inquiries about family and relationships with significant others can easily be spun to suggest that the physician was overly interested in the employee's personal life. Casual contact in a narrow hallway, such as brushing against a person while rushing between examination rooms, combined with seemingly innocent conversation, can be woven into a story strongly suggestive of sexual harassment.

The simple act of reprimanding an employee can similarly be turned into an allegation that the employer sought to exercise control and domination over the employee because of the employee's sex or ethnicity.

When that employee is terminated or does not get a raise, it is not difficult to argue to a too-receptive jury that the termination was a result of the employee's refusal to go along with a supervisor's sexual conduct or overtures or objection to the hostile work environment created by a domineering, offensive supervisor. If the plaintiff's lawyer can find a couple of patients unhappy with the way the physician listened to their

hearts, questioned them about their personal histories, or joked with them, the recipe for disaster is in place.

These fears are not merely hypothetical. Physicians have faced these allegations, and juries have awarded million-dollar judgments, not covered by insurance.

### WHAT IS SEXUAL HARASSMENT?

Since most recent court cases dealing with the creation of a disruptive work environment address issues of disruptive conduct within the context of sexual harassment, a review of this conduct can provide a better understanding of how little is required to demonstrate harassing conduct. Sexual harassment law also provides strong precedent for other types of disruptive conduct that may form the basis of claims against physicians.

Surprising to many is the fact that no sexual act is necessary for there to be sexual harassment as defined by law. Sexual harassment is harassment that occurs because of a person's sex. The harassment does not need to be sexual. For example, if a male employer treats female employees with disdain and disrespect but is respectful of male employees, the fact that there is no sexual act or even sexual comment is not relevant.

### COMMENTS ABOUT DRESS OR HAIRSTYLES BECOME ALLEGATIONS THAT THE PHYSICIAN WAS ALWAYS MAKING SUGGESTIVE REMARKS ABOUT THE EMPLOYEE'S APPEARANCE.

The simple fact that the female employees are treated less kindly than the male employees is sufficient to trigger a sexual harassment complaint. The New Jersey Supreme Court has specifically found that a case for sexual harassment may exist whenever a person:

. . . alleges discriminatory conduct that a reasonable person of the same sex. . . would consider sufficiently severe or pervasive to alter the conditions of employment and to create an intimidating, hostile, or offensive working environment.'

When the claim is not one of sexual harassment but rather that the physician is "disruptive," it need be demonstrated only that the physician created an intimidating, hostile, or offensive working environment, without regard to whether this was done because an employee was

male or female. Again, no sexual activity or comment is required.

In determining whether a workplace is "hostile," most states and the federal government require a three-part test. The first part of the test is a demonstration that the workplace was subjectively hostile: that is, the employee complaining was in fact made uncomfortable. The second criterion is that the workplace was objectively hostile. This test is met by a finding that not only the employee but any "reasonable person" of the same sex placed in that position would also be uncomfortable. The third component of the test requires a finding that the environment adversely affected the employee's ability to perform the job.

In New Jersey, however, the first and third elements of the federal test are not required. Employees need not show that they were personally affected by the conduct or unable to perform their jobs. Rather, the New Jersey Supreme Court has determined that:

[A]n extraordinarily tough and resilient plaintiff who does not find the conduct hostile or intimidating still has a cause of action where objectively the workplace is hostile or intimidating. Sexual harassment is illegal even if the



victim is strong enough not to be injured.'

The test of whether sexual harassment has occurred is therefore quite simple. As long as a reasonable woman or man (depending on the harassment alleged) would find the conduct objectively hostile, a cause of action exists against the physician.

In defining the term *reasonable woman*, the courts have held that a woman is not unreasonable merely because she falls toward the more sensitive side of the broad spectrum of reasonableness. Only a *hypersensitive* employee's subjective view that the conduct is harassing and the workplace hostile is insufficient to meet the test. According to the court, the reasonable-woman standard should not be used to reject as unreasonable an emotional response to sexual harassment. Only an idiosyncratic response of a hypersensitive plaintiff to conduct that a reasonable woman would not find harassing is excluded by the reasonable-woman standard.

By contrast, an employee who is insensitive to conduct that might be offensive to the average employee would nonetheless have a cause of action even though the conduct did not personally affront him or her. Put another way, an employee who goes along with conduct that an

average person might find offensive would still have a cause of action against a supervisor or an employer, even if that employee simply tolerated the conduct, seemed to enjoy the conduct, or actually responded to the conduct in kind.

This presents a serious dilemma to many in the workplace. Most people interact with others based on the type of response they get from the person with whom they are dealing. If a person laughs at an off-color joke, chances are another will follow. If the person, alternatively, shows offense, it is likely that jokes of that type will no longer be told in the presence of the offended person. Similarly, if a supervisor gives an employee a friendly hug and the hug is returned in kind, the supervisor will likely hug again. If the person pushes back or is nonresponsive the supervisor is not likely to repeat the conduct. An employee who is

"one of the gang" may therefore be subjected to an environment very different from that of the employee who remains aloof.

Under the New Jersey Law Against Discrimination, however, the mere fact that the employee went along and even seemed to enjoy the conduct may well prove an insufficient defense. Of course, the more severe the conduct, the less likely the defense will stand.

### **Quid Pro Quo Sexual Harassment.**

There are two types of sexual harassment defined by law. The most notorious form of sexual harassment, called *quid pro quo* sexual harassment, occurs when an employer attempts to make an employee's submission to sexual demands a condition of employment. It involves an implicit or explicit threat that an employee who does not accede to the sexual demands will suffer adverse employment consequences. It is important to note that both men and women can be subject to *quid pro quo* sexual harassment.

Since this type of harassment is easily defined and readily avoided, when it occurs it is most difficult to defend. Fortunately, it is also the most easily guarded against. Simply stated, seeking or engaging in sexual activities with employees or persons

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under a manager's direct or indirect supervision is foolhardy. As soon as the relationship sours, there is every reason to anticipate that the employee may allege that the sexual relationship was coerced.

### **Hostile Work Environment Harassment.**

*Hostile work environment* sexual harassment occurs when an employer or fellow employees harass an employee because of his or her sex to the point that the working environment becomes hostile. As discussed, the harassment does not need to be sexual in nature. It merely needs to be gender based.

The usual test for determining hostile work environment sexual harassment cases is whether the complained-of conduct:

- Would not have occurred *but for* the employee's gender.
- Was severe or pervasive in the opinion of a reasonable woman (or reasonable man).
- Would make a reasonable woman (or reasonable man) believe that the conditions of employment are altered and the working environment is hostile or abusive.

By contrast, in a disruptive-physician case, there need be no gender basis for the conduct. A physician who is crude or vulgar to all employees or simply not a nice person or abuses others is a disrupt-

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tive physician. An employee is not being abused because of his or her sex.

### **STANDARD OF PROOF**

The standard of proof in a sexual harassment case is minimal. Surprisingly, under New Jersey law, the standard of proof required for a woman to prove her case is significantly less than that required for a man. To prove sexual harassment, a woman need only show that it is more likely than not that the harassment occurred because of the plaintiff's sex. A male, by contrast, must make the additional showing that the employer is the rare employer who discriminates against "this historically privileged group."

The New Jersey Supreme Court's rationale for these different standards is based on the court's arguably sexist finding that when sexual comments or conduct are directed at them, men are apt to find it harmless and perhaps even flatter-

ing, and they are unlikely to consider it insulting or intimidating. Women, on the other hand, are more likely to find sexual conduct and comments in the workplace offensive and intimidating.

According to the court:

[B]ecause of women's status as predominantly junior and minority employees, their position in the workplace can be marginal or precarious from the start. Sexual harassment operates to further discredit the female employee by treating her as a sexual object rather than as a credible coworker. In the workplace, conduct that may be "just a joke" for men may have far more serious implications for women.

When a plaintiff alleges that she has been subjected to sexual touchings or sexual comments or . . . harassing comments about the lesser abilities, capacities, or the "proper role" of members of her sex, she has established that the harassment occurred because of her sex.'

In addition to proving that the harassing conduct action was discriminatory, a plaintiff must show that the conduct was also severe or



pervasive. In New Jersey, however, the plaintiff need not demonstrate that the conduct affected the plaintiff or the work environment. A single severe act is sufficient and the required showing of severity or seriousness of the harassing conduct varies inversely with the pervasiveness or frequency of the conduct.

## MAKING THE CASE

A female plaintiff, to show that her working conditions were affected by the harassment to the point at which a reasonable woman would consider the working environment hostile, may use evidence that other women in the workplace were sexually harassed. The ability of a plaintiff to bring in other people to support the allegations is critically important, in most instances, to the success of a sexual harassment case. If other employees testify that they have been harassed, humiliated, demeaned, or otherwise ill-treated and claim that similar conduct was not directed at employees of the opposite sex, the physician's ability to defend him- or herself is markedly impaired. In some physicians' offices, where the vast majority if not all of the support staff are women, the case that men are not ill-treated whereas women are is even easier to make, because there

are no men for the physician to ill-treat.

In a hostile work environment case, the courts have reasoned that the plaintiff's work environment is affected by conduct directed not only at the plaintiff but also at others. The plaintiff need not personally have been the target of each or any instance of offensive or harassing conduct. Evidence of sexual harassment directed at other employees is relevant to both the character of the work environment and its effects on the complainant, although (as stated earlier) the conduct need not have even affected the plaintiff. Therefore, for example, a female employee who has not herself been the subject of harassing conduct but who witnesses other female employees being harassed has a cause of action, along with those actually harassed.

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TODAY.

## CHANGING COMMUNITY STANDARDS

Much conduct that would have been considered acceptable 20 or 30 years ago would be considered sexual harassment today. As community standards evolve, the standard of what a reasonable woman would consider harassment also evolves. The courts have recognized this fact and offer no solace. Indeed, it must be remembered that a jury will not ultimately judge today's questioned conduct for perhaps three to five years. By then, the standard may be far more severe than it is even today.

## EMPLOYER LIABILITY

When an employee raises a hostile work environment discrimination claim against a supervisor, an employer will be strictly liable for equitable damages and relief. This means that an employer may be required to hire or reinstate the harassment victim; discipline, transfer, or fire the harasser; provide back pay or front pay or both; and take preventive and remedial measures at the workplace. This liability will exist even if the employer had no knowledge of and no participation in the harassing activity and even if the employer took immediate steps to resolve the problem once it was known.

When an employee raises a hostile work environment discrimination claim against a supervisor, an employer may also be vicariously liable for compensatory damages that exceed equitable relief. Compensatory damages can include damages for emotional distress, pain and suffering, and physical injury caused by the harassment. Vicarious liability will be found if the harassing supervisor acted within the scope of the supervisor's employment; if the employer contributed to the harm through its negligence, intent, or apparent authorization of the harassing conduct; or if the supervisor was aided in the commission of the harassment by the agency relationship. In other words, an employer can be held liable for compensatory damages stemming from a supervisor's creation of a hostile work environment whenever the employer grants the supervisor the authority to control the working environment and the supervisor abuses that authority to create a hostile work environment. The situation can occur in a physician's office when the physician delegates to an office manager the duty to manage, supervise, or oversee the activities of other employees. If that office manager creates a hostile work environment, the physician is liable, even if

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he or she knew nothing about it, simply because the physician gave the office manager the authority to manage, supervise, or oversee.

An employer may also be held vicariously liable for supervisory sexual harassment if the employer negligently or recklessly failed to have an explicit policy that bans sexual harassment and fails to provide an effective procedure for the prompt investigation and remediation of such claims. Many physicians now have written policies. Far fewer have an effective procedure to promptly investigate and remediate. Policy without implementation may, in fact, be far worse than no policy at all.

In addition to compensatory and equitable damages, an employer can be liable for punitive damages if it authorized, participated in, or ratified the harassing conduct. The failure of an employer to take immediate steps to resolve complaints of

sexual harassment can form the basis of a finding that the employer ratified that conduct and therefore result in the imposition of enormous punitive damages.

Successful plaintiffs are also entitled to recover their attorneys' fees from a defendant. These fees can often amount to more than the actual judgment, reaching hundreds of thousands of dollars.

### **REDUCING THE RISK OF A SEXUAL HARASSMENT CLAIM**

The burden is on the physician to act in accordance with today's standards of conduct, however ill-defined they are. Given this caveat, the best defense is to avoid any conduct that has sexual overtones and simply treat everyone with kindness and respect. While this may prove difficult, especially in a hectic, pressure-filled practice, the alternative bears significant risk. Physicians should not discuss or joke about sex or touch employees. The practice should immediately distribute a sexual harassment policy, if one is not already in place. If one is in place, it should be reviewed and the following questions addressed:

- Has the policy been properly distributed?
- Does the practice have a signed acknowledgment from each employee verifying that the



employee has received, read, and understood the policy and agrees to be bound by it?

- Is there a vehicle in place to provide a ready avenue of complaint for employees?
- Do the employees understand how to file a complaint?
- Do all employees have someone to complain to other than their immediate supervisor or the physician employer?
- Are there assurances that a complaint will not result in retaliation?

If not properly implemented, the policy offers no protection. It simply is not worth the paper it is written on.

In addition to a properly implemented policy, employees should file periodic, routine reports to identify potential problems, preferably with someone other than their direct supervisor. The reports should serve multiple purposes. They should ask employees about their job satisfaction, any problems with their jobs, and suggestions for improvements. These reports can also serve as a useful way for employees to relate their daily activities in a short, concise form. Large amounts of important management information can be obtained in a small amount of time. Offering employ-

ees the ability to e-mail their reports to a designated supervisor's personal e-mail address (as opposed to the office e-mail address) can provide assurances that any criticism, comments, or complaints will be dealt with confidentially.

These reports should be maintained indefinitely. A series of weekly or monthly reports chronicling years of job satisfaction without complaint of harassment, intimidation, or abuse may well prove to be the best defense against claims of harassment.

Any complaint suggesting a problem must be immediately investigated, documented, and resolved. Under no circumstances should the person complained of be involved in conducting the investigation. Human resources committees should be formed when the size of the practice permits. In smaller offices, especially those with only one or two employer physicians, outside resources (e.g., an outside practice management consultant or other outside advisor) should be made available to employees to provide them with an opportunity to air their complaints to a person other than the accused. Any complaint not immediately resolved requires the prompt attention of experienced legal counsel. Any complaint that

has any hint of potential trouble should be referred to counsel, so that an investigation can be conducted in a meaningful way to meet legal requirements. This is critically important, especially since both the investigation and the results of the investigation will likely be discoverable if litigation ensues.

## CONCLUSION

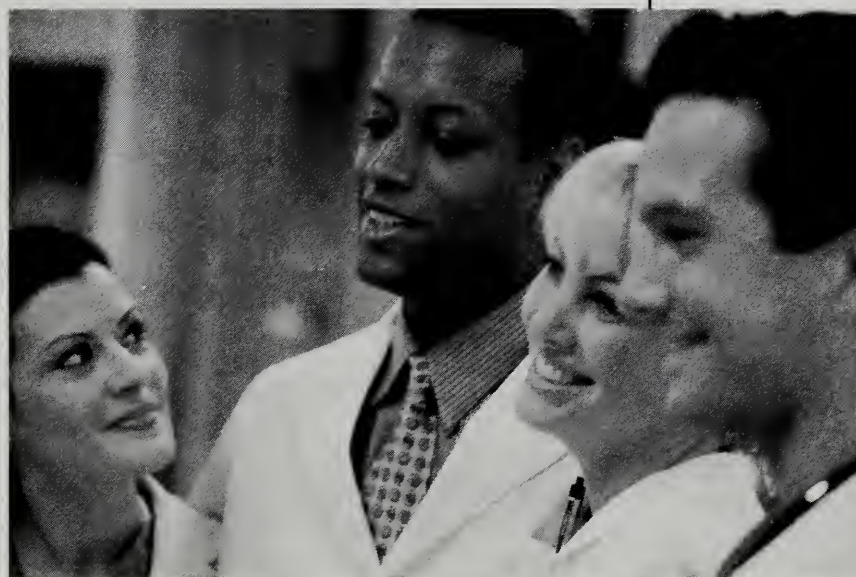
Today, acts of disruptive conduct are every bit as serious as acts of medical malpractice. Such acts can result in loss of hospital privileges and managed care contracts as well as tremendous financial liability. Unlike malpractice judgments, judgments for disruptive conduct and, in particular, punitive damage judgments, are not covered by most insurance policies. Behavior that was considered acceptable 10 years ago may well constitute illegal conduct today. For better or worse, today's laws require physicians, employers, and supervisors to be on their best behavior and to remain vigilant in their pursuit of those who make the work environment a "hostile" place.

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# Umbilical Cord Blood Stem Cell Transplantation and Banking

BANKED UMBILICAL CORD BLOOD FROM UNRELATED DONORS IS A SUBSTITUTE SOURCE OF

STEM CELLS FOR TRANSPLANTATION IN PATIENTS WITH HIGH-RISK BLOOD DISEASES

IN THE ABSENCE OF HLA-MATCHED SIBLING DONORS.

*Richard D. Huhn, MD*

Several diseases of the blood and immune system may be effectively treated by hematopoietic stem cell (HSC) transplantation, in which the diseased blood-forming tissues are replaced with normal blood stem cells from healthy donors. Diseases that may be amenable to HSC transplantation include hematologic malignancies such as acute and chronic leukemias; lymphomas and multiple myeloma; hemoglobinopathies such as thalassemias and sickle cell disease; and congenital immunodeficiencies.

Several sources of HSCs for transplantation have been developed. Traditionally, transplants

have been performed with bone marrow obtained by multiple needle punctures and aspiration from the donors' pelvic bones. Collection of bone marrow thus requires general anesthesia and entails some risk with considerable inconvenience and discomfort for the donor. HSCs can also be collected from donors' peripheral blood by apheresis after treating the donor with cytokines such as G-CSF to mobilize the HSCs into circulation. Interestingly, mobilized blood HSCs seem to engraft more efficiently than bone marrow cells.

Recently, blood of the umbilical cord and placenta has been recognized as a potentially rich source of

HSCs for transplantation. It has long been known that blood of the placenta and umbilical cord has a very high content of HSCs. Blood from the umbilical vein can be collected without risk or discomfort to the mother or baby. During the late 1980s it was proposed that sufficient numbers of HSCs to support transplantation in children, and possibly adults, could be collected from umbilical veins during delivery. In 1988, the first cord blood transplant procedure was performed to supplant the defective bone marrow of a child with Fanconi's anemia. The procedure was successful and the recipient remains alive and well. Since that time, more than one



thousand cord blood transplants have been performed internationally. Most of the transplants have been for child recipients; however, there have been a number of successful cord blood transplants in adults.

## ADVANTAGES OF CORD BLOOD FOR HSC GRAFTS

Immunocytes of an allogeneic stem cell graft often recognize the recipient's (host's) tissues as foreign. For that reason, HSC transplantation is frequently complicated by graft-versus-host disease (GVHD), in which the colonizing immunocytes of the graft incite inflammation and damage to various tissues of the recipient. GVHD can lead to serious disability or death, even after the original disease has been eradicated. To minimize the frequency and severity of GVHD, HSC grafts are generally obtained from donors who are siblings of the patient and are matched with the patient for HLA markers (tissue type). Even with HLA-matched grafts, however, a substantial number of patients develop GVHD. Unfortunately, for any individual patient, the chance of finding a complete HLA match is only approximately 25% for each sibling. The low chance of finding matched sibling donors has engendered sev-

eral investigational endeavors to identify alternative donor sources. One important alternative source is HLA-matched unrelated donors, for which a number of national and international bone marrow registries have been created. Incompletely matched donors who are related to the patient represent another important source. Unfortunately, but not unexpectedly, transplantation using alternative stem cell sources, especially HLA-mismatched donors, entails significant increases in the risk of serious GVHD.

Tissue matching for ethnic minority (i.e., nonwhite) populations is challenging. Some HLA markers are segregated in ethnic groups, reducing the likelihood of matching an individual with the general population. In addition, minor antigenic determinants of transplantation compatibility that

are not identified in HLA typing may also segregate by ethnic groups. Even with complete HLA matches, differences in the minor histocompatibility antigens may increase the likelihood of a GVHD reaction from cells of ethnically disparate donors.

As indicated by several lines of research, cord blood cells are immunologically immature and may be less likely to cause severe GVHD than adult blood HSC grafts. Cord blood contains fewer T-lymphocytes than adult blood. Furthermore, cord blood lymphocytes do not respond as strongly as adult lymphocytes to immune stimuli. In addition, selective unresponsiveness (anergy or tolerance) of cord blood lymphocytes may be induced by some immune stimuli. Thus, even incompletely matched cord blood may be more tolerant of recipients' tissues than cells derived from adult blood.

## DISADVANTAGES OF CORD BLOOD FOR HSC GRAFTS

The major disadvantage of cord blood for HSC transplantation is related to the small volume of blood that can be obtained from the placenta and umbilical cord. The usual cord blood collection volume ranges approximately from 75 mL to 100 mL and contains roughly  $10^9$  nucle-

**BLOOD OF THE PLACENTA AND UMBILICAL CORD HAS A VERY HIGH CONTENT OF HSCs, AND BLOOD FROM THE UMBILICAL VEIN CAN BE COLLECTED WITHOUT RISK OR DISCOMFORT TO THE MOTHER OR BABY.**

ated cells. In contrast, a cytokine-mobilized blood stem cell graft collected from an adult by leukapheresis would ordinarily contain 10-fold to 50-fold more nucleated cells, with a proportionately larger content of stem cells. The speed of a patient's posttransplant hematologic recovery, which largely determines the risk of infection and bleeding and the requirements for antibiotics and blood product transfusions, is related to the number of HSCs infused for transplantation. Accordingly, the recovery of leukocyte and platelet counts after cord blood transplants is generally quite prolonged compared with adult-derived stem cell transplants. Considerable research efforts are being invested in the US and internationally on the development of cell culture technology to expand cord blood stem cells, with the goal of improving the efficiency and outcomes of transplantation.

## CLINICAL EXPERIENCE WITH CORD BLOOD TRANSPLANTATION

Several groups of investigators are pursuing the use of cord blood as an alternative source of HSCs for transplantation in patients with malignant and nonmalignant blood diseases. By far the largest number of cord blood transplants performed to date has been for the

### EVEN INCOMPLETELY MATCHED CORD BLOOD MAY BE MORE TOLERANT OF RECIPIENTS' TISSUES THAN CELLS DERIVED FROM ADULT BLOOD.

treatment of high-risk or relapsed acute leukemia in children. Typically, for individual patients, transplantation of cord blood has been chosen because of the unavailability of related matched marrow or blood HSC donors. In the recently updated experience of the Eurocord investigators (a cooperative group of European experts in HSC transplantation who are focusing on the development of cord blood transplantation), children who underwent cord blood transplantation during first or second remission of acute lymphoblastic or acute myeloid leukemia enjoyed a two-year event-free survival rate of 49%. Not surprisingly, children with more advanced disease had lower survival rates. The frequency of clinically significant acute GVHD was approximately 40% in both patients who received grafts from related and unrelated donors despite the high frequency of HLA disparity in the unrelated recipients.

While salvage treatment for hematologic malignancies is clearly an important application for a developing therapeutic technology such as this, an even more exciting potential application is in the treatment of hemoglobinopathies. For example, sickle cell disease is a prevalent cause of significant morbidity and early demise in the US and throughout the world. The thalassemia syndromes are major public health problems in the Middle East, Africa, and Asia.

HSC transplantation has the potential to cure hemoglobinopathies by replacing part or all of the patient's source of abnormal red cells with a source of healthy red cells. Several clinical studies of allogeneic transplantation for sickle cell disease have been performed with grafts from HLA-identical sibling donors. The outcomes of allotransplantation are generally optimistic with respect to resolution of sickle complications such as vaso-occlusive events, splenic dysfunction, and bony abnormalities. The cumulative incidence of graft rejection or recurrence of sickle cell disease has been very low. Unfortunately, allotransplantation entails a high rate of acute and chronic GVHD, which may be considered unacceptable for younger patients who have not yet developed symptomatic disease. On



the other hand, higher rates of transplant-related adverse events have been observed in older and symptomatic patients. Umbilical cord blood stem cell transplantation offers the possibility of wide availability of grafts with less risk of acute GVHD than from unrelated bone marrow or blood stem cells.

## PUBLIC BANKING OF UMBILICAL CORD BLOOD

The major impediment to wide availability of HSC allotransplantation is the low probability of identifying HLA-matched marrow or peripheral blood stem cell donors. The better tolerability of mismatched and unrelated cord blood grafts has stimulated interest in the development of public cord blood banks from which to obtain HSC grafts for candidate transplant patients who do not have matched related donors. In general, there is enthusiastic acceptance of the practice of cord blood banking by candidate donors and by the general public. The collection procedure, which involves simple venipuncture of the umbilical vein and drainage of the blood into a collection bag containing anticoagulant, poses no risk to the donor mother or baby. The placenta and cord have traditionally been considered to be waste material and would otherwise be discarded.

Several steps are performed to screen out cord blood collections that would be inadequate or inappropriate for transfusion. Mothers who wish to designate their baby's cord blood for donation to a public bank must provide thorough medical and family historical information and have blood tests for infectious disease to minimize the risk of disease transmission via later transfusion of the cord blood to recipients. In addition, tests for infectious disease markers and bacterial cultures are performed on the cord blood. Results of routine newborn screening for hemoglobinopathy are also reviewed. If the cord blood unit is to be used for transplantation in a

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HEMOGLOBINOPATHIES.

patient with an enzyme deficiency, then an aliquot of the cord blood is itself screened for enzyme deficiency. Of course, all information that could potentially identify a donor or expose private health information is kept securely confidential.

Acceptability requirements also include a minimum volume or nucleated cell count for which the commonly accepted criteria are either 60 mL (exclusive of anticoagulant) or  $6 \times 10^8$  total nucleated cells, respectively. For permanent frozen storage, cord blood units are tested and catalogued by HLA type (HLA-A, -B, and -DR) which is the primary set of parameters to identify qualified units for transplantation. Additional search parameters and quality characteristics include demographic information (ethnic derivation), the volume of the cord blood unit, differential white cell count, immunophenotype, and cell viability.

To maximize its use as a public resource, a cord blood bank must have a broad diversity of HLA types and ethnic origins among its inventory. The target populations for outreach and educational efforts must include minority and socio-economically disadvantaged groups, as well as the majority or educated and affluent population of the regions and communities the bank

will serve. There may be various misconceptions and apprehension regarding the donation process and the eventual uses of the donated blood that must be overcome. Carefully planned large-scale community information activities, as well as physician education, will be required to convey the message that the beneficiaries of the banked cord blood are both the community at large and the minority subgroups that might otherwise be unable to locate tissue-type matched units.

### THE NEW JERSEY CORD BLOOD BANK

In 1999 the New Jersey legislature established funding to develop a public umbilical cord blood bank for the citizens of the region. The resource, called the New Jersey Cord Blood Bank, is housed at the Coriell Institute for Medical Research in Camden. Two or more medical centers in geographically dispersed locations across the state with a variety of ethnic representation will be recruited to participate in the program. Enrollment of donors and cord blood collections will be performed by specially trained technologists or by obstetrical professionals who are trained and certified in the collection procedures. As the results of clinical trials of cord blood transplantation are reported and become more widely understood, it is antic-

## THERE IS ENTHUSIASTIC ACCEPTANCE OF THE PRACTICE OF CORD BLOOD BANKING BY CANDIDATE DONORS AND BY THE GENERAL PUBLIC.

ipated that there will be an increasing demand for cord blood grafts. ■

*Richard D. Huhn is director of the Umbilical Cord Blood Stem Cell Laboratory at the Coriell Institute for Medical Research in Camden.*

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# A Provider's Risk Management Services Checklist

Maureen Mondor

*FIRST INCIDENT:* The man burst into the doctor's office and ran to the receptionist. "Help me, it hurts!" he said. He was told to fill out some forms and wait, and the doctor would be with him shortly. No one asked what the problem was. He paced and waited. Finally, he couldn't take it any more. "Please, I'm having chest pains!" he blurted in the middle of a crowded waiting room. The doctor, speaking with a patient behind closed doors, had no idea that any of this was happening. But the stage had been set for a medical malpractice claim against her.

*SECOND INCIDENT:* The office manager was tired. Still, she had hours of work to do, transcribing requests for prescription renewals that patients always left on the office answering machine. She rubbed her eyes. "Xanax, 150 mg," she heard the patient say. The office manager called in the order to the pharmacy. Unfortunately, the prescription should have been for Zantac, a fact that would have been recognized if the office manager had consulted the patient's chart. The doctor had no idea that any of this was going on. And again, the stage was set.

Medicine today is a complicated art and involves much more than providing the best care possible to patients. Thanks to the expanded reach of vicarious liability, for example, doctors can be held legally accountable for a range of behaviors by other individuals in their practices. Even as savvy and as knowledgeable as health care providers are about the intricacies of managed care and the specter of malpractice suits, some are still in the dark when it comes to certain risks that are occurring on their watch—from vicarious-liability issues to breaches of confidentiality to compliance failures.

The examples at the beginning of this article are based on factual cases. The good news, however, is that today's risk management offerings are more powerful and wide-ranging than ever before when it comes to

helping doctors address the risks in their practices.

## RISK MANAGEMENT OFFERINGS

Risk management organizations offer a range of services and products—including publications, educational seminars, and office evaluations—aimed at reducing the risks in doctors' practices. An effective risk management consultant closely examines doctors' practices, keeps physicians informed about relevant standards, and generally gives health care providers the tools they need to focus on their patients and stay ahead of the changes in health care today.

Because of the number of applicable standards (e.g., compliance, environmental, and employee safety) and the changing nature of modern health care, today's health care providers need to select risk management offerings that provide a broad range of innovative mecha-



nisms for ensuring quality of care. Risk management services, once offered only by medical malpractice insurers, are now becoming independently available in response to popular demand. Today a physician can select quality risk management offerings from risk management experts who are not part of the doctor's medical malpractice insurance group. As a result, physicians have a broader range of risk management offerings to choose from than in the past.

This article provides a checklist of some components that may be part of a risk management package. This list, which is representative, not comprehensive, can help physicians evaluate their current risk management needs and determine which features they may want to consider when seeking risk management services.

## OFFICE APPRAISALS

An office appraisal is an in-depth, on-site assessment of a provider's office practice or ambulatory care facility. A thorough office appraisal is a "best-practice" tool to strengthen clinical excellence, cost efficiency, safety in practice, and patient satisfaction.

Some of the areas that an office appraisal can address are:

General practice  
Scheduling  
Medical records system  
Telephone policies and procedures  
Follow up  
Medication

Billing policies and procedures  
Emergency planning  
Infection control  
Office environment  
Medical records audit  
Radiology

*Table 1. Areas Typically Reviewed in an Office Appraisal.*

- Administrative systems and practice issues—How can providers better balance patient needs with time restrictions and financial constraints?
- Compliance—How effective is the practice's compliance program?
- Environmental and employee safety concerns—Are standards being met?

Table I lists the areas that a risk management service typically covers in an office appraisal.

## PUBLICATIONS AND EDUCATIONAL SEMINARS

Every health care provider knows that education doesn't end with medical school. On the contrary, providers are constantly updating themselves to stay current with changing practice norms. With so much new education available, staying on top of practice trends and changes can be a daunting undertaking. This is another area where risk management services can help. A

service may offer publications designed to keep the health care professional current with risk management trends. Like other medical trade magazines and newsletters that providers have come to count on, these publications feature helpful articles written by experienced medical or risk management professionals. Issues addressed in these publications might include such topics as:

- Confidentiality.
- Vicarious liability.
- The drug-seeking patient.
- Clinical risk management protocols.
- Recent research studies (ask if they are conducted by or with practicing physicians), including statistical models for predicting different malpractice lawsuit outcomes.

If the availability of publications is a factor in the selection of risk management services, the physician should ask to see sample publica-

tions to evaluate their quality. Publications should include case studies, analyses of actual situations, and concrete risk management suggestions.

Another factor the practice should consider when choosing a risk management service provider is whether it offers educational programs. Programs offered by professional risk managers can be particularly helpful in alerting a physician to new risks in the profession. Educational programs addressed by a risk management group might include:

- Changing risks in the office practice.
- Dealing with difficult patients and situations.
- Maximizing the usefulness/protection of medical records.
- Medication protocols.
- Informed consent.

Health care providers may also be able to arrange for educational seminars tailored to meet their specific interests. Risk management staff members may coordinate programs for small or large group practices, ambulatory care facilities, individual hospital departments or entire hospital staffs, regional medical societies, or for any other group, organization, or institution based on a particular risk management need.

For example, an OB/GYN group could request a personalized seminar on risk management issues related to breast cancer.

## CONSULTATIVE SERVICES

A risk management services provider may also offer consultative services tailored to providers' specific concerns. These can include a meeting or series of meetings either in person or by telephone to help health care providers and staff develop risk management strategies, implement proven risk management systems, and interpret the implications of practice mandates and regulations.

No matter which risk management services provider the physician chooses, it is important for the practice to feel comfortable with its choice. Choosing a risk management partner carefully after fully evaluating the competition can do wonders to reduce risks and improve patient satisfaction, officewide communication, and the ability to provide quality care. Most of all, in the changing world of health care, good risk management services can provide increased comfort for both patient and physician.

*Maureen Mondor is vice president of risk management at ProMutual Group, a provider of risk management services based in Boston.*

## Risk Management Services Checklist

The following checklist can be used when the practice is evaluating risk management service providers:

### Office Appraisals

- \_\_\_Are office appraisals available?
- \_\_\_Do they provide standard recommendations?
- \_\_\_What specific issues and practice areas do they cover?
- \_\_\_Are they specialty specific?
- \_\_\_Are they automated?
- \_\_\_How are the results reported?

### Publications

- \_\_\_Are publications made available to providers?
- \_\_\_Do they cover useful subjects?
- \_\_\_Are they written by physicians or risk management experts?
- \_\_\_Do they include case studies and actual risk management suggestions?

### Educational Programs

- \_\_\_Are educational programs available to providers?
- \_\_\_Do they cover current, useful subjects?
- \_\_\_Are they taught by physicians, attorneys, and risk management experts?
- \_\_\_Are there both on-site and online offerings?
- \_\_\_Are CME credits available?
- \_\_\_Can programs be customized to fit specific needs?

### Consultative Services

- \_\_\_Are consultative services available to providers?
- \_\_\_Are they available by telephone for immediate needs?



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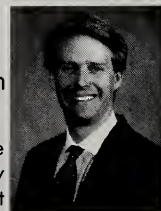
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# A Mighty Task

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## Remarks on the Swearing-in of Paul W. Armstrong as Superior Court Judge

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PAUL W. ARMSTRONG, AN INTERNATIONALLY NOTED BIOMEDICAL ETHICIST, A FRIEND OF THE MEDICAL SOCIETY OF NEW JERSEY, AND AN ASSOCIATE EDITOR OF *NEW JERSEY MEDICINE*, WAS RECENTLY INSTALLED AS JUDGE OF THE SUPERIOR COURT OF NEW JERSEY. THE FOLLOWING ARE REMARKS THAT JUDGE THOMAS H. DILTS ADDRESSED TO THE NEW JUDGE AND TO THE LARGE AUDIENCE THAT WAS PRESENT FOR THE OCCASION.

Paul, this is a wonderful day: for you and for the people of New Jersey. For you, because as you put on the judicial robe, you assume the mantle of responsibility to faithfully and impartially help the people resolve their disputes. You are well prepared, and so amid the challenge you will find satisfaction—and even joy—as you help people who come before you seeking fairness and justice. This is a wonderful day for the people of New Jersey because we are privileged to have you become a Judge of the Superior Court.

Judging and, to a large degree, judges have changed over the years. Consider this: less than 45 years ago, in Somerset County we had one superior court judge and one county court judge. Twenty-five years ago, there were a total of four judges

sitting in Somerset County. We now have eight judges, expect two more in coming months, and have two judges temporarily assigned to assist us. Instead of this wonderful temple of justice as the seat of justice [the historic courthouse in Somerset County], we have the modern courthouse on North Bridge Street as our primary home. There we have many courtrooms and administrative offices, with lots of room to accommodate the large number of people who come in daily seeking to have their disputes resolved. The architecture is flexible so that space can be reconfigured quickly to meet the changing needs of the court system to better serve the public. These are the physical changes.

But, starting with Chief Justice Robert N. Wilentz and continuing with Chief Justice Deborah T.

Poritz, a greater change can be found in how we judge. We have a sharper focus on our role of serving the public. No longer do judges simply manage and decide cases—we help people resolve their disputes. We recognize our role in the complex dynamic of conflict between the parties that causes them to come to court. We emphasize that we are called on to treat all who come into our courtrooms with courtesy and respect.

Last year, there were more than 1,000,000 court cases filed in the Superior Court of New Jersey. This is an approximately threefold increase of cases in the past 25 years. In Somerset County Family Part alone, Judge Graham T. Ross and I conclude about 8,000 cases each year. Paul, the volume of work for each judge is staggering—and you will find



this to be especially true in your assignment in the Family Part. Understand that the people we deal with are not happy. My father told me when I became a judge that at least the 50% of the people who won should be satisfied—even if the other 50% are not. What I quickly came to learn was that very few of them are happy or satisfied. Those who “win” believe they deserve to win and are frustrated by the cost of litigation and the slow pace of justice. And the reality is that no one really “wins” in litigation—including those who prevail.

A 1999 survey by the National Center for State Courts concludes that nationally only 53% of the American public surveyed believed that the courts in their states handled civil and criminal cases in an excellent or good manner. Less than a majority, only 43%, believed that courts handled family matters in an excellent or good manner.

On a brighter note, Paul, we as judges are privileged to serve in the Superior Court of New Jersey, which is recognized nationally as one of the best, if not *the* best, court system in America. You spoke eloquently at my swearing-in on the fine tradition of justice in New Jersey since the 1947 constitution. The challenge, however, to all of us, especially those

YOU HAVE ADVOCATED FOR  
THE CRITICALLY ILL AND  
THE DYING AND HAVE  
INFLUENCED CHANGES IN  
THE BODY OF LAW THAT  
HAVE AFFECTED OUR  
WHOLE NATION—INDEED,  
CIVILIZED SOCIETIES  
AROUND THE WORLD.

of us privileged to serve in the best of the state court systems, is—in each case—to do better. Along with court employees, jurors, attorneys, and volunteers who work with us, our job is to resolve disputes justly and to do so promptly with courtesy and respect and as economically as possible.

A mighty task indeed! But a task so important that the rule of law—the glue that holds our society together—quite literally depends on our continued success.

So today, Paul, we welcome you. You have been privileged in your career to deal with issues of life and death. In the finest traditions of our profession, you have advocated for the critically ill and the dying and have influenced changes in the body of law that have affected our whole

nation—indeed, civilized societies around the world. You have helped define when life ends and to establish acceptable life care choices for us as children of God and as members of a civilized society.

The same compassion, thoughtfulness, and wisdom you brought to bear on these issues will be needed in judging. In your assignment to the Family Part, you will be called on to help mothers, fathers, children, and families who are in great pain. Your care and your judgment will be needed to help these people and those whom they love get through the worst times of their lives.

It sounds like a hard job—and it is! But for most of us, it is the most fulfilling and rewarding life to be lived.

Justice Virginia Long, in a presentation to Family Part judges earlier this year, said it best, and I use her words as my closing:

If you view this as an opportunity to live a life above the life lived by the average person, not in a material sense, but a life of the MIND, the HEART, and the SPIRIT, and you carry out your obligations with CREATIVITY, INDUSTRY, INTELLIGENCE, COMPASSION, and DECENCY, there is no end to the return that you will receive.

# Against Relativism: Cultural Diversity and the Search for Ethical Values in Medicine

Ruth Macklin

New York: Oxford University Press, 1999

304 pp., \$32.95

ISBN: 0195116321

Global commerce and electronic communication create the perception of universality. Information now travels readily between countries, creating an impression that the world has become a global village. With globalization comes high-tech medicine, with the ability to prolong life, manipulate genes, and replace hearts. The power of medicine is such that it cannot escape its role as a moral compass.

But, wherever mobile cultures go, they bring their unique rituals, traditions, beliefs, and their own "absolute" truths. In a world ad-

dicted to technological change, these worldviews anchor us in what may be part bedrock and part shifting sand. Rutgers University professor Benjamin Barber, an advisor to President Clinton on citizenship, writes in his book *Jihad vs. McWorld: How Globalism and Tribalism Are Reshaping the World* (New York: Ballantine Books, 1996) that tensions between tribalism and globalization will increase.

These realities have not escaped the examining rooms. A family committed to their unique traditions may bring their 11-year-old daughter in for genital surgery,

inescapably female genital mutilation to us, but to them essential for the child's capacity to marry and "be happy." A pediatrician notes burn marks on a young infant's abdomen; the caring mother does this to relieve the child's discomfort. Do we report the mother to the Department of Youth and Family Services? What responsibility does medicine, as a profession, and we, as health professionals, have to learn, understand, respect, and, possibly, change the beliefs of others?

As physicians, compassion compels us to listen and attend to human dignity and human rights. What



frames of reference, what road maps, then, are best for all concerned? That is the context and intent of this book.

Ruth Macklin, PhD, professor of bioethics at Albert Einstein College of Medicine in the Bronx and a lawyer-medical ethicist with global experience, is the ethicist "on watch" at Montefiore Hospital in the Bronx and serves on special committees at the United Nations and in the World Health Organization, principally in the areas of reproductive practices and research.

Dr. Macklin, by presenting real-life problems and challenges, both at bedside and through skillful Socratic questioning, walks us (at times kicking and screaming?) through complex and challenging problems. She leads us on an odyssey covering philosophical, anthropological, religious, governmental, scientific, and sexist viewpoints about human dignity and medicine.

Ultimately, she focuses an ethical and moral lens on us to help us understand that physicians and health care systems have, at once, the burden and opportunity to enhance human dignity.

Various chapters cover what she views as the dangers of cultural relativism, the postmodern concept that there are no universals. She urges that participant-observers of other

cultures would do well to respect the differences. Third-world feminists complicate matters by defining issues only through the challenge to male power, and they accuse universalists like Macklin of pushing "Western thought." She counters by referring to Immanuel Kant: "So act," he wrote, "that the moral of thy doing shall, at thy will, become universal law," that is, moral choices are valid only if they are principles that ought to be universal.

Dr. Macklin discusses how our notions of autonomy may be incompatible with the views of certain subcultures. For example, the Navajo believe in the power of language to create realities. How should we reconcile our views of informed consent when a Navajo patient is told that he could die from surgery? She observes that, in some Asian countries, no concept exists of the individual outside the context of community.

A chapter on the rights of female infants, infanticide, and the rituals surrounding organ transplant and brain death require that medicine be alert to the power of culture. We must approach differences with the goal of dignity and individual rights.

What is the role of research on HIV/AIDS in Africa, where death is expected and no treatment is commonplace? What about confiden-

tiality and informed consent when the family dynamic, particularly in relationship to the male/female asymmetry, interferes with such an event as an out-of-wedlock pregnancy? Later chapters take us toward the polestar of human rights and dignity. Building on Eleanor Roosevelt's declarations of "man-kind's rights," Macklin challenges the notion that everything is relative. She provides methodologies to work through issues of informed consent and privacy by respecting families' involvement and with a heavy reliance on intermediates.

In the end, she comes down clearly on the side of ethical universals in medicine. Health care, as a social phenomenon, must address human rights. We would still be in the Dark Ages had we not progressed through humanness and humanity to a state where human rights are recognizable and upheld. As she says, "Once we uphold and promote human rights, we have taken a stance against relativism."

As the economic realities of health care delivery create chaotic change, it is comforting to know that professionals like Ruth Macklin are on watch to remind us that by paying attention, we will perform a more efficient, inclusive, and compassionate service.

**Joseph F. Fennelly, MD**, former chair and current vice chair of the Biomedical Ethics Committee of MSNJ.

## PEOPLE IN THE NEWS

**Michael Kane, MD, FACP**, medical director of the Cancer Institute of New Jersey at Hamilton, and **John Pennacchi, MD**, associate director, were recently honored by Robert Wood Johnson Medical School for their educational leadership of medical residents in a hematology/oncology elective. Each received a teaching award. Dr. Kane has also been listed in the 2000 edition of the Castle Connolly Guide *How to Find the Best Doctors: New York Metro Area*.

Valley Home Care enterostomal nurse coordinator **Mary Sugrue, RN, BSN, CWOCN**, has been awarded the 2000 Governor's Nursing Merit Award from the New Jersey Department of Health and Senior Services in the Registered Professional Nurse: Long-Term Care/Community Health category.

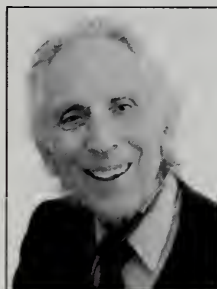


Gary R. Brickner, MD

**Gary R. Brickner, MD**, chairman, department of OB/GYN at Robert Wood Johnson University Hospital at Hamilton was recently selected by the New Jersey Department of Health and Senior Services and the Central New Jersey Maternal and Child Health Consortium to serve on the statewide Maternal Mortality Case Review Team. Dr. Brickner has also been listed in the 2000 edition of the Castle Connolly Guide *How to Find the Best Doctors: New York Metro Area*.

**Randi Altmark, BSN**, registered nurse and clinical care manager of the operating room at Virtua West Jersey Hospital Voorhees, was recently certified for professional

achievement in perioperative nursing practice by the National Certification Board: Perioperative Nursing, Inc.



Seymour Charles, MD

**Seymour Charles, MD**, was recently acknowledged by the Saint Barnabas Medical Center Department of Pediatrics for his 50 years of service to children. He has long worked for child car safety,

more recently worked to enact legislation requiring new mothers to be allowed a 48-hour hospital stay, and most recently is working on gun awareness.

**Mary Campagnolo, MD**, has been elected president of the New Jersey Academy of Family Physicians. Dr. Campagnolo is chief of the department of family practice at Virtua Memorial Hospital of Burlington County and a representative on the Physician Council of Virtua Health System.

**Megan Reilly, DO**, and **Brian Horn, DO**, received the annual Alan Z. Gartzman, DO, Family Practice Award for exhibiting exceptional traits and personal and professional qualities. Dr. Reilly is with Winslow Family Physicians in Berlin; Dr. Horn is relocating to a family practice in Delaware.

**John R. Middleton, MD, FACP**, was named 1999 Distinguished Physician of the Year by the Board of Directors of Raritan Bay Medical Center, where he is medical director and chair of the department of medicine.

**David O. Sussman, DO**, has been named medical director of the

Kennedy Continence Center in Voorhees. Dr. Sussman is a urologist with Kennedy Memorial Hospitals—University Medical Center.

**Stephen J. Pilipshen, MD**, has been appointed president of the Burlington County Medical Society. While serving as a colorectal surgeon on staff at Virtua Health Memorial Hospital of Burlington County, Dr. Pilipshen partnered and founded the Colon Rectal Surgical Center of South Jersey in 1999.



Robert R. Rickert, MD

**Robert R. Rickert, MD**, has been appointed chair of the department of pathology at Saint Barnabas Medical Center after serving as cochair for more than 25 years. Dr. Rickert is clinical professor of pathology at the UMDNJ-NJ Medical School.



John L. Caplan, MD

**John L. Caplan, MD**, has joined the Robert Wood Johnson University Hospital at Hamilton in the department of medicine, section of cardiology. Dr. Caplan practices with Mercer Regional Cardiology in Trenton and Hamilton.

**John S. Salaki, MD**, has been appointed president of the Morris County Medical Society. Dr. Salaki is an internist with a subspecialty in infectious disease with offices in Morristown.

The emergency department of Monmouth Medical Center honored **Marvin Broder** on his retire-



ment as a volunteer in that department since 1993, after serving 22 years as a member of the hospital's board of trustees.

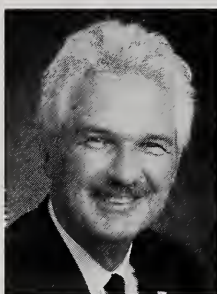
Saint Barnabas Medical Center

welcomed **Gregory J. Rokosz, DO, JD, FACOEP**, as its new director of medical education and program director for the transitional year residency program. He is also the new vice president for medical education for the Saint Barnabas Health Care System.

**Mary Fednik, MPH, RNC**, has been named director of Valley Health Affiliates, a home health agency associated with the Valley Home & Community Health Care and Valley Health System.

Kennedy Health System president and CEO **Richard E. Murray** has been named chairman-elect of the New Jersey Hospital Association board of trustees, has been appointed to the board of trustees of Rowan University in Glassboro, and was named a recipient of the Good Neighbor Awards presented by the Camden County Chapter of the American Red Cross.

The New Jersey Organ and Tissue Sharing Network has announced that **Jeffrey A. Warsh**, executive director of the New Jersey Transit Corp., has been named to its board of trustees.



Charles L. "Rex" Riley

The Children's Specialized Hospital, an affiliate member of the Robert Wood Johnson Health System, has named **Charles L. "Rex" Riley** as its president and CEO.

### DISSERTATION ASSISTANCE AWARD DEADLINE APPROACHES

A dissertation assistance grant funded through the American Health Information Management Association's (AHIMA) Foundation of Research and Education (FORE) encourages research of both theoretical and practical aspects of health information practice. Applicants for the grant must be an active, associate, or student AHIMA member enrolled in an accredited doctoral degree program in an area related to health information management (business management, computer science, education, public health, etc.). All requirements for the doctoral degree, other than the dissertation, must be completed by the award date. Submissions require a letter of support from the faculty member responsible for supervising the applicant's dissertation research, as well as a completed application that provides details regarding objectives, methodology, and evaluating systems of the dissertation research. The fall deadline for submissions is September 29, 2000.

For an application, visit AHIMA's Web site at [www.ahima.org](http://www.ahima.org) and follow links to "FORE" and "Dissertation Assistance Grant." Members can also call the association's fax link at (888) 424-4040 and request documents 507 and

508. For more information, contact Alison Feinberg at (312) 233-1168 or via e-mail at [alison.feinbeg@ahima.org](mailto:alison.feinbeg@ahima.org).

### MONMOUTH MEDICAL CENTER LABORATORY EARNS NATIONAL CERTIFICATION

The Laboratory at Monmouth Medical Center earned accreditation from the College of American Pathologists following an on-site inspection of its quality procedures and technical proficiencies. The laboratory provides diagnostic tests, research into the cause and specific pathology of disease, and genetic and other cell marker studies. For more information on laboratory services at Monmouth, call (732) 923-7380.

### KENNEDY MEDICAL STAFF AWARDS \$8K IN SCHOLARSHIPS

The medical staff of the Kennedy Health System recently awarded scholarships of \$2,000 each to four South Jersey high school graduates of the class of 2000 for use in their educational pursuits in anticipation of careers in the health care industries. The scholarships mark the first time that funds collected from the medical staff at Kennedy have been used to support a community service program.

### SAVE THE DATE

**Women in Medicine**  
**Saturday, October 7, 2000**  
**9 to 11 AM**  
**Woodbridge Hilton**

Honoring Assemblywoman  
Loretta Weinberg with the  
Palma E. Formica Award  
Theme: Computers in Medicine  
**(609) 896-1766, ext. 245**

## SUPPORT FOR HEALTH CARE VOLUNTEERISM

Physicians, dentists, and other health care professionals have created services to provide health care for the uninsured in their communities. Volunteers in Health Care has created a Web site to provide a central source of information to identify models, collect information, and share experiences. The organization's activities include:

- Capturing the experiences of projects in other communications and disseminating them on the Web.
- Developing materials and tools to help programs begin or sustain their efforts.
- Working with other organizations to explore solutions to such barriers as access to prescription medications and availability of dental care.
- Creating tools such as RxAssist, a database with instructions and forms about accessing pharmaceutical manufacturers' patient-assistance programs.
- Organizing educational and networking activities.
- Offering small grants to encourage solutions and replicate successful models.

Volunteers in Health Care is based at Brown University Center for Primary Care & Prevention at Memorial Hospital of Rhode Island and is funded by a grant from the Robert Wood Johnson Foundation in Princeton NJ.

For more information, call (877) 844-8442 or visit [www.volunteersinhealthcare.org](http://www.volunteersinhealthcare.org).

## AETNA GIVING FREE INTERNET ACCESS TO HEALTH CARE PROFESSIONALS

Aetna US Healthcare announced agreements with Hewlett-Packard Company (HP) and NetZero, Inc., to give computer discounts and free Internet access to all physicians, dentists, pharmacists, nurses, and medical students in the US.

The HP discount program will enable health care professionals to purchase a 500MHz business PC from HP complete with a mouse, keyboard, and 15-inch color monitor. An HP Deskjet color inkjet printer with cable is also part of the package. The HP business PC is loaded with Microsoft Windows 98 software and Microsoft Internet Explorer along with HP's instant-help software.

NetZero will provide a CD-ROM containing software and instructions on how to download the necessary Internet access software. Once installed, the NetZero software will provide unlimited Internet and e-mail access with no monthly fees.

Aetna US Healthcare has established a toll-free line, (888) Aetna-49, to order a discounted computer from HP or receive free Internet and e-mail access from NetZero. Any health care professional or student pursuing a

professional degree in health care can take advantage of this offer regardless of their network participation status with Aetna US Healthcare.

## SUNY AT ALFRED TO OFFER INTERNET- BASED CODING AND REIMBURSEMENT TRAINING PROGRAM

The State University of New York, College of Technology at Alfred is now offering an Internet-based coding and reimbursement specialist training program. Internet-based courses will be offered each semester depending on enrollment. Tuition is \$137.50 per credit, payable on registration. To determine potential as an Internet student, go to <http://web.alfredtech.edu/greenma/autosurvey.htm> and complete the survey. For more information about the program, contact Michelle A. Green at (607) 587-3674 or [greenma@alfredtech.edu](mailto:greenma@alfredtech.edu).

## SEND US A SURVEY QUESTION!

Visitors to our Members-Only home page have the opportunity to respond to a series of ongoing member surveys on topics of interest to New Jersey physicians. Do you have a question that you'd like to ask of the membership? For consideration, send the question (and three suggested answers) to [info@msnj.org](mailto:info@msnj.org). (While you're at [www.msnj.org](http://www.msnj.org), don't forget to fill out the e-mail form and sign up for E-News Service.)



# A E N D A

**E V E N T**
**D A T E**
**L O C A T I O N**
**S e p t e m b e r 2 0 0 0**

|                                                                     |                        |                                                                  |
|---------------------------------------------------------------------|------------------------|------------------------------------------------------------------|
| <b>MSNJ Board of Trustees Meeting</b>                               | September 17           | Lawrenceville NJ, (609) 896-1766                                 |
| <b>World Congress of Gynecology and Obstetrics</b>                  | September 17-22        | Washington DC, (514) 286-0855                                    |
| <b>MSNJ Council on Medical Services</b>                             | September 20           | Lawrenceville NJ, (609) 896-1766                                 |
| <b>5th International Conference on Geriatric Oncology</b>           | September 21-23        | Marriott Marquis, New York NY, (770) 751-7332                    |
| <b>New Developments in Retinal Disease and Vitreous Surgery</b>     | September 22           | Baltimore MD, (410) 328-5934                                     |
| <b>Overcoming Communication and Ability Differences</b>             | September 22           | Saint Peter's University Hospital, New Brunswick, (732) 745-8600 |
| <b>American College of Radiology Annual Meeting</b>                 | September 23-27        | New York Hilton & Towers, New York NY, (703) 716-7545            |
| <b>Lung Transplantation—Update</b>                                  | September 26           | Mount Sinai Hospital, New York NY, (212) 241-3079                |
| <b>Public Health: CARE Leadership Coalition</b>                     | September 27           | Lawrenceville NJ, (609) 896-1766                                 |
| <b>MSNJ Council on Legislation</b>                                  | September 27           | Lawrenceville NJ, (609) 896-1766                                 |
| <b>American College of Emergency Physicians Scientific Assembly</b> | September 28-October 8 | Philadelphia PA, (214) 550-0911                                  |

**O c t o b e r 2 0 0 0**

|                                                         |             |                                                          |
|---------------------------------------------------------|-------------|----------------------------------------------------------|
| <b>Chronic Fatigue Syndrome Conference</b>              | October 1   | Sheraton Conference Center, Eatontown NJ, (973) 635-4361 |
| <b>Clinical Endocrinology—Update 2000</b>               | October 1-4 | Philadelphia PA, (301) 941-0200                          |
| <b>Pediatric Radiology</b>                              | October 2-6 | Washington DC, (202) 782-2268                            |
| <b>Biocontaminants and Biological Production Issues</b> | October 3-4 | Hilton Alexandria Hotel, Alexandria VA, (617) 630-1300   |
| <b>American Society of Human Genetics</b>               | October 3-7 | Philadelphia PA, (301) 571-1825                          |
| <b>American Society of Bariatrics Physicians</b>        | October 3-7 | Washington DC, (303) 770-2526                            |
| <b>Lymphoma and Myeloma 2000</b>                        | October 5-7 | New York NY, (770) 751-7332                              |



## INTERNATIONAL COLLEGE OF ACUPUNCTURE & ELECTRO-THERAPEUTICS

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Nov. 17-19, 2000

440 W. 57th St, NYC between 9 & 10 Ave.

Dec. 15-17, 2000

Hotel tel. 212-581-8100 during meetings

#### 16th Annual International Symposium, October 19-22, 2000 School of Int'l Affairs, Columbia University

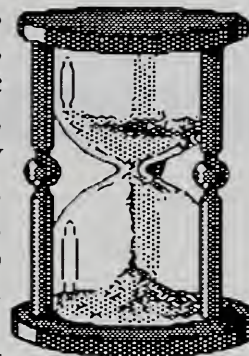
In addition to holding 7-8 seminars & workshops per year, the International College of Acupuncture & Electro-Therapeutics organizes an Annual International Symposium every October at the School of International Affairs, Columbia University, NYC and publishes *Acupuncture & Electro-Therapeutics Research*, *The International Journal* quarterly, through Cognizant Communications and is listed by 15 major international indexing periodicals (*Index Medicus*, *Current Content*, *Excerpta Medica*, etc.), is recognized as a major leading journal in the field. The most prestigious and internationally recognized, "Fellow of the International College" (F.I.C.A.E.) will be awarded to members of the College who present a minimum of 2 original research papers during the annual International Symposium and publish them in the official journal, or made significant contributions in the field.

These seminars, workshops & int'l. symposium train physicians and dentists in the latest theories & techniques of manual and electro-acupuncture.

For information, contact Dr. Y. Omura, MD, ScD, FICAE, 800 Riverside Drive (8-I), NY, NY 10032; 212-781-6262, Fax 212-923-2279 or Dr. Richard Simon, PhD, 212-662-7022. All ICAE meetings are accredited by the NY State Boards for Medicine & Dentistry and NJ Acupuncture Examining Board and other State Boards towards 300-hour requirement for the Acupuncture Certificate. Also eligible for AMA/CME Category I Credit. This activity has been planned and implemented in accordance with the essentials of ACCME, through the joint sponsorship of the NY Academy of Medicine and the International College. The NY Academy of Medicine is accredited by the ACCME to provide CME for physicians and takes responsibility for content, quality and scientific integrity of this CME activity. The NY Academy of Medicine designates this CME activity for category I credit towards the AMA/Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

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To learn how to prevent a full  
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[www.stroke.org](http://www.stroke.org)

**NSA**

**National Stroke Association**



## E V E N T

## D A T E

## L O C A T I O N

## O c t o b e r 2 0 0 0

|                                                                                      |                           |                                                                   |
|--------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------|
| <b>3rd Annual Symposium on Alternate Bearing Surfaces in Total Joint Replacement</b> | October 6-7               | Westin Hotel, Philadelphia PA, (215) 898-6400                     |
| <b>Seminar of Legal-Medical Issues</b>                                               | October 10-23             | Colonial Cruise departs New York NY, (800) 521-0076               |
| <b>Sports Medicine Seminar</b>                                                       | October 11                | Lawrenceville NJ, (609) 896-1766                                  |
| <b>1st International Geriatric Palliative Care Congress</b>                          | October 11-14             | New York NY, (514) 286-0855                                       |
| <b>The Fetus and Newborn: State-of-the-Art Care</b>                                  | October 11-14             | Crystal Gateway Marriott, Washington DC, (925) 828-7100           |
| <b>Ophthalmology for the Medical Practitioner</b>                                    | October 12                | Baltimore MD, (410) 955-2959                                      |
| <b>Contemporary Nuclear Cardiology</b>                                               | October 12-14             | Heart House, Bethesda MD, (301) 897-2694                          |
| <b>8th Conference on Radioimmunodetection and Radioimmunotherapy of Cancer</b>       | October 12-14             | Princeton NJ, (973) 844-7007                                      |
| <b>Managing Respiratory Diseases</b>                                                 | October 13-15             | Marriott Marquis, New York NY, (800) 421-3756                     |
| <b>Cardiovascular Imaging Conference</b>                                             | October 13-15             | Philadelphia PA, (800) 373-2204                                   |
| <b>American College of Gastroenterology</b>                                          | October 13-18             | New York NY, (703) 820-7400                                       |
| <b>MSNJ Board of Trustees Meeting</b>                                                | October 15                | Lawrenceville NJ, (609) 896-1766                                  |
| <b>MSNJ Council on Public Health</b>                                                 | October 18                | Lawrenceville NJ, (609) 896-1766                                  |
| <b>Cardiology for the Noncardiologist</b>                                            | October 21-22             | New York NY, (201) 342-5300                                       |
| <b>American College of Emergency Physicians</b>                                      | October 21-24             | Philadelphia PA, (800) 798-1822                                   |
| <b>Fundamentals in Critical Care Course</b>                                          | October 26-27             | Danville PA, (717) 531-6483                                       |
| <b>American College of Rheumatology</b>                                              | October 28-<br>November 2 | Pennsylvania Convention Center<br>Philadelphia PA, (404) 633-3777 |

## N o v e m b e r 2 0 0 0

|                                                      |               |                                 |
|------------------------------------------------------|---------------|---------------------------------|
| <b>Genetics for the Primary Health Care Provider</b> | November 1-3  | Washington DC, (202) 782-2637   |
| <b>American Society of Cytopathology</b>             | November 7-11 | Philadelphia PA, (302) 429-8802 |

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**Addiego, Frank J., MD** August 23, 1934–March 30, 2000. University of Rome (1963), Camden County, General Practice.

**Baumgardner, Selina B., MD** December 28, 1931–May 13, 2000. University of Maryland (1957), Morris County, Research Administration.

**Benza, Lawrence P., MD** September 2, 1921–February 15, 2000. State University of New York Medical Center (1952), Morris County, General Practice.

**Bergsma, Daniel, MD** April 4, 1909–November 23, 1999. Yale University School of Medicine (1938), Mercer County, Public Health.

**Brown, James M., MD** March 24, 1924–April 4, 2000. University of Paris (1951), Essex County, Radiation Oncology.

**Cano, Harold V., MD** September 10, 1920–April 13, 2000. University of Maryland (1946), Middlesex County, General Practice.

**Cavalier, Ralph, MD** May 5, 1936–May 29, 2000. Hahnemann Medical College (1963), Atlantic County, Orthopedics.

**Chappen, Edward P., MD** 1925–January 4, 2000. Jefferson Medical College (1952), Mercer County, Psychiatry.

**Crotty, Martin J., MD** 1926–May 16, 2000. National University of Dublin (1950), Morris County, Family Practice.

**Diamond, Joseph G., MD** October 23, 1908–July 16, 2000. University of Maryland (1932), Union County, General Practice.

**Flicker, David Jonas, MD** June 2, 1919–April 2, 2000. University of Louisville (1933), Essex County, Neurology and Psychiatry.

**Gilbert, Samuel M., MD** November 26, 1907–May 4, 2000. University of Pennsylvania (1930), Essex County, Internal Medicine.

**Honig, Charles, MD** June 17, 1915–July 10, 2000. Albany Medical College (1943), Passaic County, Surgery.

**Kovaleski, Walter A., MD** February 27, 1908–June 3, 2000. Boston University School of Medicine (1934) Passaic County, General Practice.

**Kristal, J. John, MD** August 1, 1910–July 10, 2000. Edinburgh School of Medicine (1937), Bergen County, General Practice.

**Lavine, Samuel C., MD** March 26, 1911–April 20, 2000. University of London (1938), Middlesex County, General Practice.

**Levinson, Percival P., MD** 1922–April 22, 2000. Hahn Hospital (1955), Camden County, General Practice.

**Massarelli, Lucian G., MD** October 28, 1923–April 28, 2000. St. Louis University (1947), Bergen County, Cardiology.

**Messina, Thomas A., MD** November 17, 1908–April 14, 2000. Loyola (1934), Essex County, Obstetrics/Gynecology.

**Morrissey, Kenneth A., MD** November 30, 1924–July 16, 2000. University of Virginia (1954), Bergen County, General Practice.

**Pine, Harry L., MD** June 16, 1927–May 20, 2000. Boston University (1957), Middlesex County, Obstetrics/Gynecology.

**Prentice, Stanley E., MD** July 25, 1913–May 21, 2000. Columbia University (1941), Bergen County, Psychiatry.

**Reilly, Thomas F., MD** January 31, 1910–June 30, 2000. Columbia University (1937), Passaic County, Surgery.

**Reinhardt, Warren I., MD** October 14, 1910–October 1, 1999. Harvard Medical School (1935), Essex County, Internal Medicine.

**Richter, Emanuel J., MD** October 31, 1906–April 23, 2000. University and Bellevue Hospital Medical School (1930), Morris County, Cardiology.

**Risk, Abraham, MD** November 6, 1931–July 18, 2000. Dalhousie University (1957), Morris County, Obstetrics/Gynecology.

**Rivas, Leon D., MD** November 12, 1915–April 17, 2000. University of St. Thomas (1944), Morris County, General Surgery.

**Samuel C., MD** March 26, 1911–April 20, 2000. University of London (1938), Middlesex County, General Practice.

**Siddiqui, Nurul H., MD** January 27, 1936–May 31, 2000. Prince of Wales Medical College (1961) Cumberland County, Internal Medicine.

**Slatkin, Marvin W., MD** September 28, 1930–May 6, 2000. Lausanne University (1957), Atlantic County, Dermatology.

**Strassburger, Paul, MD** March 14, 1914–June 1, 2000. University of Pennsylvania (1939) Essex County, Orthopedic Surgery.

**Vincent, Nicholas F., MD** August 13, 1907–March 26, 2000. Jefferson Medical College (1933) Essex County, Neurology and Psychiatry.

**Walsh, Charles, R., MD** August 20, 1909–March 25, 2000. Georgetown University, (1932) Essex County, Obstetrics/Gynecology.

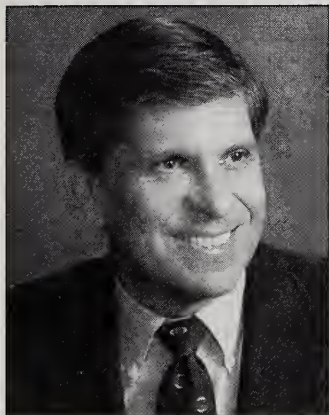
**Ward, C. Prentiss, MD** September 11, 1910–April 14, 2000. Cornell (1937), Essex County, Pediatrics.



## In Memoriam

### RALPH J. CAVALIER, MD, NATIONALLY NOTED ORTHOPAEDIC SURGEON AND EDUCATOR

*Paul J. Hirsch, MD*



Dr. Ralph J. Cavalier, an orthopaedic surgeon who practiced in Atlantic County and was on the faculty of Hahnemann University in Philadelphia, died at home on May 29, 2000. He was 64 years old.

Dr. Cavalier was a graduate of Princeton University and Hahnemann Medical College and had been a flight surgeon in the Air Force during the Vietnam War.

As a general orthopaedist who specialized in spine surgery and joint replacement surgery, he practiced his entire career with Atlantic Shore Orthopaedic Associates. He was on the staff of Atlantic City Medical Center, where he had done his internship and where he later served as chairman of the orthopaedic department and president of the medical staff.

During the malpractice crisis that affected physicians in New Jersey and throughout most of the country during the 1970s, Dr. Cavalier was a leader in the movement to form a doctor-owned insurance company. Although ordinarily quiet and soft-spoken, he was a dynamic and compelling public speaker, and he frequently addressed this issue at meetings throughout the state. He urged doctors to take the initiative and form their own company, so that professional liability insurance would always be available to them.

After MSNJ formed the MIIX Insurance Company, Dr. Cavalier was a strong supporter of the

company. He later served on MIIX's finance and investment committee and claims committee. On this latter committee, he was especially noted for his ability to clearly evaluate the medical aspects of complex pending litigation and accurately define the strengths and weaknesses of the case.

Dr. Cavalier also served as president of the New Jersey Orthopaedic Society from 1980 to 1981, when that organization had recently begun a series of educational programs that were then uncommon for state specialty societies. He helped to develop and strengthen these programs, which continue today and which became a national model for other state orthopaedic societies. Dr. Cavalier later served as the chairman of the regional admissions committee of the American Academy of Orthopaedic Surgeons.

He was a member of many other professional societies, including the Atlantic County Medical Society, which he served as president; the American Medical Association; the North American Spine Society; the Philadelphia Orthopaedic Society; and the Academy of Medicine of New Jersey.

He is survived by his wife of 34 years, Carole; a daughter, Gwen Cavalier, who is an art teacher and jewelry designer; a son, Dr. Ralph J. (Buck) Cavalier, Jr, who recently started an orthopaedic residency at Hahnemann University and is currently rotating through Atlantic City Medical Center; a daughter-in-law, Dr. Ashley Celis Cavalier, also a resident at Hahnemann; and by his mother, Mrs. Anna Cavalier.



# NEW JERSEY MEDICINE

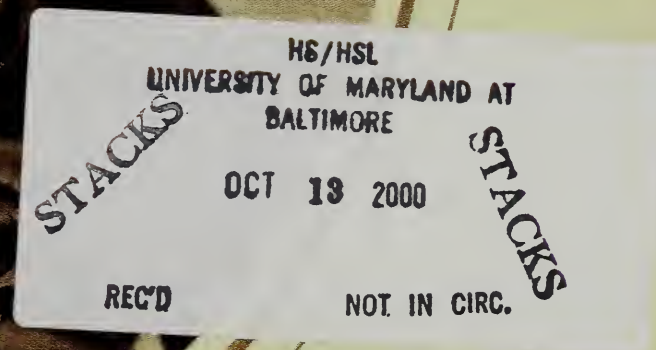
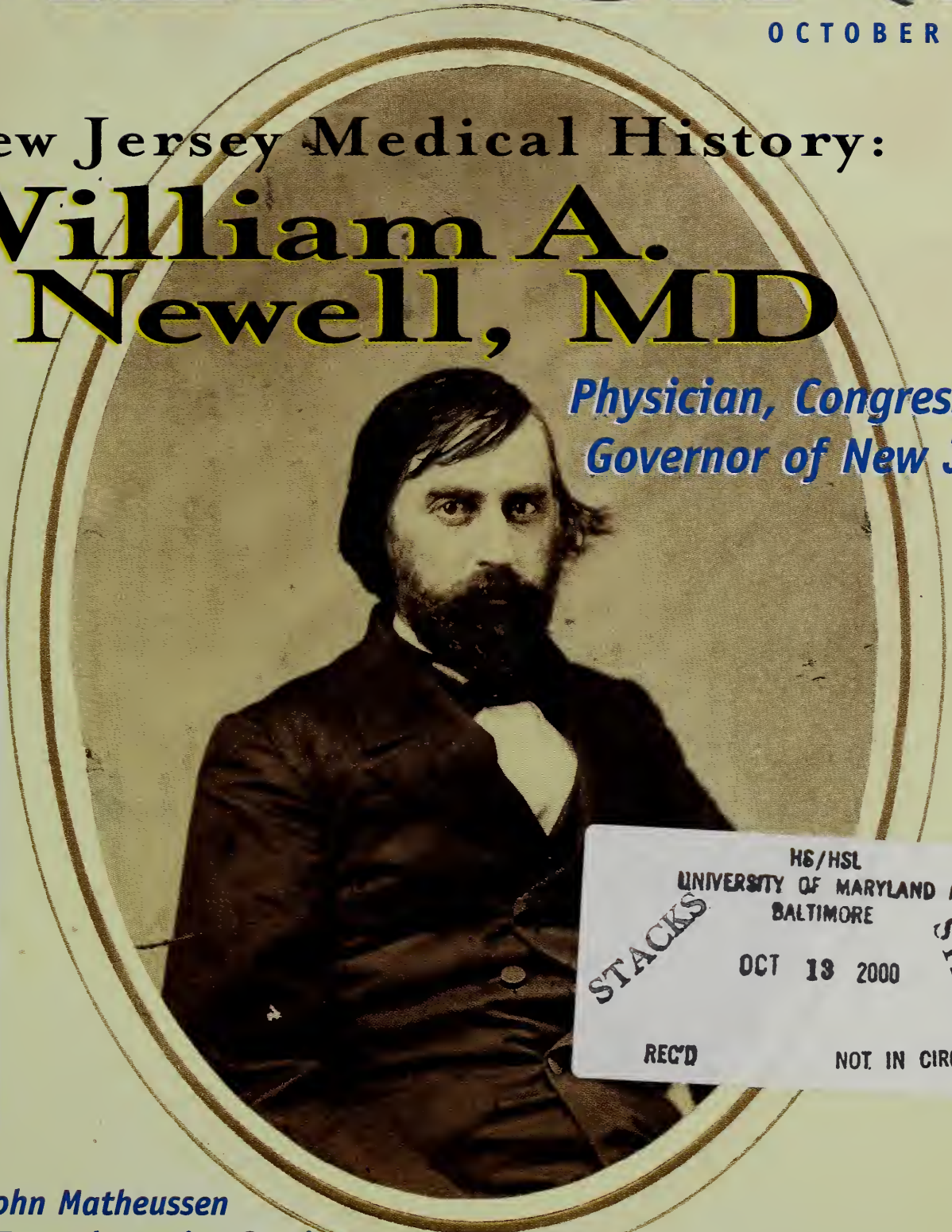
HEALTH CARE IN THE GARDEN STATE

OCTOBER 2000

New Jersey Medical History:

## William A. Newell, MD

*Physician, Congressman,  
Governor of New Jersey*



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## First-time endorsements in the 2000 race

As the health care tumult has reached even politicians, New Jersey physicians see some elected officials as more responsive, more attuned to medical realities, than others. So last month, MSNJ's federal political action committee, JEMPAC, decided for the first time to make endorsements in this year's US senatorial and congressional races.

Taking a public position in political campaigns is a bold step for medical observers. But as Darwin wondered, "How can anyone not see that all observation must be for or against some view if it is to be of any service?"

In a letter sent to all MSNJ members, JEMPAC announced its support for Senate candidate Bob Franks and congressional candidates Jim Saxton, Mike Ferguson, and Rush Holt, all locked in tough contests.

JEMPAC also supports Representatives Robert E. Andrews, Frank A. LoBiondo, Christopher H. Smith, Marge Roukema, and

Frank Pallone, Jr. Also backed are Representatives Bill Pascrell, Jr., Steven R. Rothman, Donald M. Payne, Rodney P. Frelinghuysen, and Robert Menendez.

### REACHING THE UNINSURED

In an outstanding presentation at a Forums Institute session, Brian Baxter, an aide to Governor Whitman, outlined the complex decisions involved in creating FamilyCare. This new program extends coverage to the parents of uninsured children and others.

A related, earlier initiative, KidCare, now reaches about two-thirds of New Jersey children with family incomes below 200% of the federal poverty level, according to Baxter. Another 10,000 children above that level also are enrolled.

And New Jersey Care 2000+, with a rollout date of October 1, is moving recipients of aged, blind, and disabled assistance—as well as clients of the Division of Developmental Disabilities—into the Medicaid managed care pro-

gram. Camden, Hudson, and Mercer counties are the launch sites for New Jersey Care 2000+.

Do physicians have a stake in these program expansions, given New Jersey Medicaid's historically abysmal physician reimbursement rates? The Whitman administration is sweetening the pot to attract physicians. In a landmark move,

**F**eds unreachable? You just can't let down your guard when dealing with certain federal agencies. Or, at least the AMA doesn't let down its guard. The association has written to the Inspector General of Health & Human Services to protest some of the more problematic aspects of the draft compliance program for individual and small group practices.

Specifically, the AMA objects that physicians will need to hire consultants and spend valuable personal and staff time to demonstrate compliance with fraud and abuse standards. The standards are extremely rigorous, in any event.

Gov. Whitman and Senate President Donald T. DiFrancesco have announced support for higher physician fees. Further, the administration is pumping \$2.4 million into "incentive" payments for primary care physicians who conduct (and document) early, periodic screening, diagnosis, and treatment exams.



## LEGAL MATTERS

New Jersey occupational physicians employed by Concentra Medical Centers won a clear victory in a hearing before the National Labor Relations Board. The board's regional director has ordered elections to establish a unit of Physicians for Responsible Negotiation, the AMA's new collective bargaining program. Attorneys for the employer had argued that the employed physicians were supervisors and therefore outside the protection of federal labor laws.

Our state's HMOs may be on the brink of filing another lawsuit against the state. Perhaps they're enjoying suing the Department of Banking and Insurance over the HIP bailout fund and want to double their fun by suing the Department of Health and Senior Services over new guidelines on patient appeals.

The new guidelines require HMOs to notify patients, hospitals, and physicians about decisions to deny hospital days in time for appeals. The guidelines further require HMOs to offer an alternative when ordering a hospital discharge to a less intensive setting.

Furthermore, the guidelines reiterate several provisions in the

state's progressive HMO regulations: the ban on retroactive denials; the prudent-layperson definition of emergencies; the right of providers to submit appeals with the patient's consent; time frames for processing internal appeals; and complaint procedures. Additional guidelines declare that the rigorous utilization management provisions in the regulations govern denials of supposedly cosmetic, experimental, or dental procedures.

Bryan A. Liang, professor of law and medicine at Southern Illinois University, has predicted some unintended consequences of the Joint Commission on Accreditation of Healthcare Organizations' proposed sentinel-events policy. Writing in *Health Affairs*, Liang suggests that the self-reporting of medical errors to the commission, together with subsequent root-cause analyses, could be discoverable by plaintiffs in malpractice suits. Furthermore, he argues, reports to the accreditation body and not to a hospital's insurer could allow the insurer to deny legal support and indemnification.

## ARE HMOs SATISFYING?

A patient who believes that he or she is enrolled in an HMO is less likely to express satisfaction with health care, according to a new

Center for Health Systems Change Issues Brief. "The managed care backlash is a major force shaping health care policy," note analysts for the center, who conclude that "policy makers and researchers should exercise caution in drawing conclusions about HMO and non-HMO differences from survey data."

AMA spokespersons are expressing optimism about Aetna US Healthcare's new CEO, John W. Rowe, MD, an AMA member who has headed Mount Sinai Medical Center in New York.

## MEDICARE REFORM DEBATE

*Health Affairs* focuses on Medicare reform in its latest issue. Authors advocate competitive pricing for Medicare+Choice (which unites HMOs, hospitals, and physicians in opposition) and reorganization of our friendly Health Care Financing Administration.

Lawrence S. Seidman proposes "prefunding" Medicare through individual savings accounts. And Jonathan Oberlander criticizes the "premium support" or "defined contribution" approach recently advocated by George W. Bush. Oberlander says this approach favors HMOs and would hurt the seriously ill. We'll see how political winds blow.

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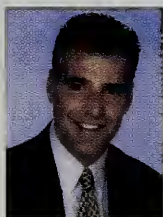
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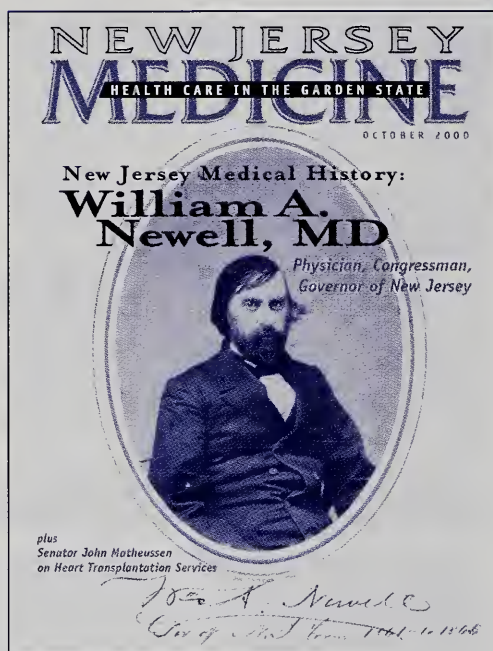


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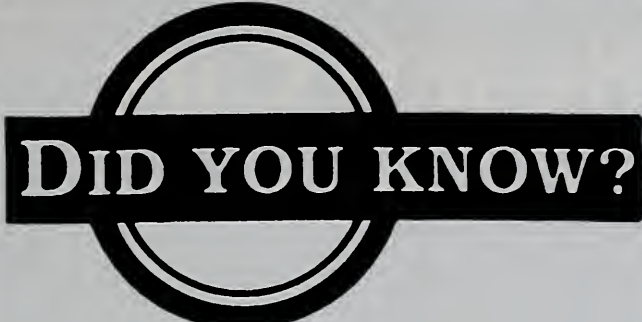
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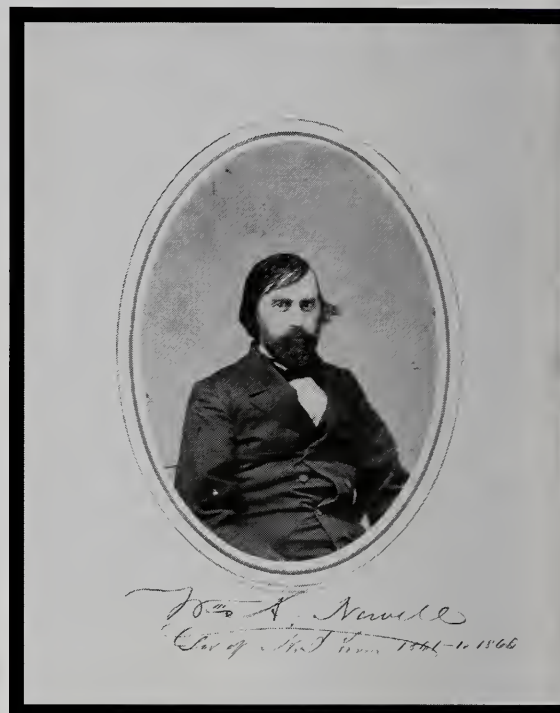
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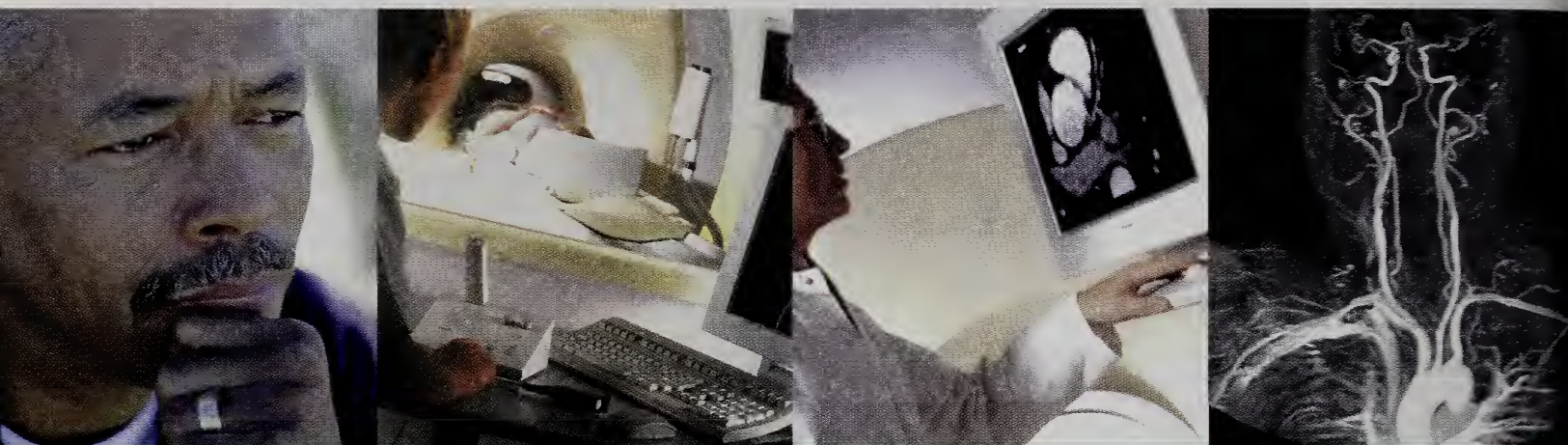
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## WILLIAM A. NEWELL, MD, PHYSICIAN AND PUBLIC SERVANT

Dr. William Augustus Newell, a New Jersey physician, lived a life dedicated to public service and medicine. His career demonstrates an interest in public health and public policy, long before many others recognized any relationship between these fields of endeavor.

His first public health issue was the safety of shipwreck victims along the New Jersey coastline, and he helped to solve the problem by drafting legislation as a congressman. But that is only a small part of his story. Dr. Newell, featured this month on our cover and in a biographical study by Dr. Henry H. Sherk, had an amazingly varied career.

Dr. William Newell, who was born in 1817, was a practicing physician with wide and diverse interests and accomplishments. He served three terms in the US Congress and a term as governor of New Jersey and was later the governor of Washington Territory. He was White House physician to President Lincoln and is credited with saving the life of Lincoln's son. He was the founder of an organization that was the forerunner of the US Coast Guard. He served a term as president of the New Jersey Agricultural Society and later as president of the New Jersey State Board of Agriculture. He was still practicing medicine when he died in 1901.

Dr. Sherk also points out a jarring note in the midst of these successes: Dr. Newell was censured by the Medical Society of New Jersey for an activity that would not be questioned today.

In a recent issue, *New Jersey Medicine* profiled a modern-day physician, Dr. Herbert C. Conaway, Jr, who also combines careers as a public servant in elective office and as a practicing physician. Another recent example is Dr. Harold Colburn, a practicing dermatologist who served in the state assembly for many years. These leaders and others show the value to the public of physician involvement in "politics."

The article about Dr. Newell in this issue is one of a series on New Jersey medical history by Dr. Sherk, who has recently joined the editorial board of *New Jersey Medicine*. Readers can look forward to future articles on a regular basis. (An earlier study of Dr. Newell, by Dr. Peter Guthorn, appeared in this publication in 1984.)

Our cover is from a Civil War-era photograph made from an original glass negative. The thin line across the photo, near the bottom, is the result of a crack in the glass. Dr. Newell's stern and forbidding appearance is characteristic of many portraits of that time, when being photographed was a special and uncommon event. We obtained the photograph from the Rutgers Library, especially appropriate since Dr. Newell was a graduate of and later a trustee of Rutgers College.

Paul J. Hirsch, MD

## PERSON OF THE YEAR

Last month we called for nominations for the *New Jersey Medicine* Person of the Year 2000. There is still time to submit your recommendations, and we will print as many as we can. Previous recipients of this honor have included Gov. Christine Todd Whitman, Commissioner Len Fishman, Dr. William Hait, Dr. Stanley Bergen, and Dr. Steven Schroeder.

When submitting nominations, you may include a brief summary of achievements (no more than 100 words) or may submit name and identification only. Send your suggestions to the editor by mail to *New Jersey Medicine* or by e-mail at [info@msnj.org](mailto:info@msnj.org).

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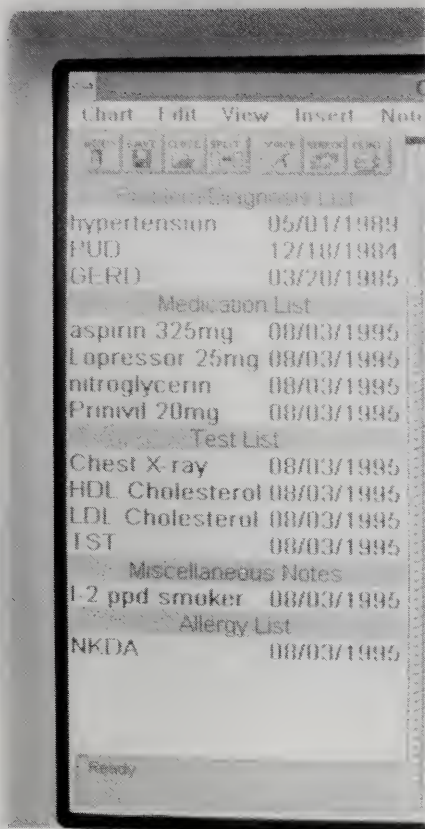
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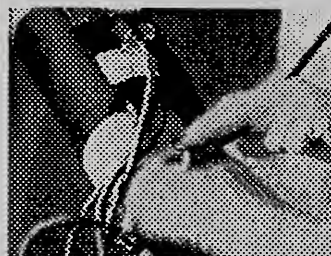
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## Selman Waksman and the Academy of Medicine

As a former history major and medical history buff, I very much enjoy the New Jersey Medical History section of *New Jersey Medicine*. Dr. Henry Sherk has done an excellent job of bringing to life some of the giants of New Jersey's distinguished medical past.

I particularly enjoyed the article on Selman Waksman (August 2000). Readers may be interested to know that for Dr. Waksman's work in developing streptomycin he was presented with the Academy of Medicine of New Jersey Citizen's Award in 1961. The award, which is presented "to that citizen or group of citizens of New Jersey who merit recognition by the Academy for distinguished service in the interest of the health and welfare of the community at large," was established in 1956.

Another interesting development in the academy's history, which happened in 1961, was the establishment of a section on basic medical sciences, thus paving the way for persons holding non-medical doctoral degrees in allied disciplines to enjoy full fellowship in the academy. There is no written evidence that Dr. Waksman's award and the founding of the section are related, but one might guess that there is a connection.

Thank you for the opportunity to comment and keep up the good work.

*Charles J. Heitzmann*  
Executive Director  
Academy of Medicine of New Jersey

## A call for unity

As you can see from the article by Dr. Walter J. Kahn, "A Change for the Better" (August 2000), we are going through a very distressful time in our professional lives. It is

time for us to join forces. Since Monmouth and Ocean counties are so close to each other—geographically, demographically, and medically—I don't see why we cannot do this so that the society will be stronger. In fact, it would not be a bad idea once we get going to ask Middlesex county to join us. But first things first. Let's do this, which is going to benefit practically everybody in both counties.

I have known Dr. Kahn for a number of years. We couldn't have a better president in the society. We are lucky to have him for his vision and interest.

*David A. Yazdan, MD, FACS*  
Brick

## More suggestions for the House of Delegates

Regarding "Suggestions for the House of Delegates" (June 2000), I would like to suggest the following:

- Streamline the annual meeting agenda to eliminate items that could be communicated in writing rather than taking up valuable time at the meeting.
- Require the makers of resolutions to present factual data to authenticate their statements.
- Establish a two-day meeting of the House of Delegates and members two weeks before the annual meeting to allow reference committees to present, debate, and support, reject, or amend the resolution or make substitutions. The reference committees' recommendations to the House of Delegates would not be further debatable unless two-thirds vote in favor.
- Resolutions or recommendations to the Board of Trustees should be encouraged throughout the year. They need to be dealt with in a timely fashion as

there may be too much lapse before the annual meeting for them to be considered.

- Provide pre- or postconvention CME programs.
- Reserve political action involvement at convenient times.

The Golden Merit program should be continued but presented when a full day can be devoted to honor its recipients appropriately. Perhaps this program can be combined with political action activities that might include workshops.

*Frank J. Malta, MD, FACP*  
Toms River

If there is a need to have the resolutions checked for authenticity and consequences, the work of the reference committees may be further refined by convening the reference committees before the annual meeting. The members should be allowed to express their opinions. Resolutions could be amended as a result of the hearings at the reference committees.

Individuals could also be encouraged to bring resolutions to the Board of Trustees if they choose. This way, individuals can be given two chances—one at the Board of Trustees meeting and one at the reference committee meeting before the annual meeting.

*K.S. Pitta, MD, FAAP*  
Toms River

## Reader appreciation

Regarding "Goodbye, Abe" (Reflections, August 2000): Beautifully written. It's a shame that we can't teach this profound compassion to our younger physicians. Unfortunately, the prevailing attitude in clinical medicine doesn't appreciate or understand this trait!

*Herve M. Byron, MD, FACS*  
Englewood Cliffs



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# Decreasing Medical Errors: The Pilot's Way

Walter J. Kahn, MD, President, MSNJ

There have been two provocative articles in the media recently on the topic of medical errors. One, from the Institute of Medicine, reported that preventable adverse events are a leading cause of death—causing as many as 98,000 Americans to die every year. The second, in the *Journal of the American Medical Association* (JAMA), disputed the institute's report, calling it flawed and exaggerated.

Now there is a clamor from our federal government for the establishment of a Center for Patient Safety, within the Agency for Healthcare, Research, and Quality, where adverse events and errors would be reported and safety programs would be developed. Many of our hospitals are developing similar programs.

In my opinion, however, the emphasis should not be on the number of adverse events and errors. Even one is too many. The emphasis should be on *prevention*.

The medical community could learn a lot by looking at the aviation industry. Aviation is just as interested in preventing human errors as the health care industry. Aviators have tackled this problem with a realistic approach and have produced excellent results.

The aviation industry assumes human errors will occur, and emphasis is placed on reducing them to the lowest number possible.

One important method to achieve this is to report near misses—accidents that could have happened but did not. In aviation, near misses must be reported to the FAA Aviation Safety Reporting System within 10 days. The reporting member—whether a pilot, crew member, or controller—is assured that his or her identity will be kept confidential and there will be complete immunity for the incident, as long as no injury has occurred. In this system, the aviation industry has recognized that to err is human, and no matter how

careful or how conscientious one is, errors will happen. Through the reporting of these incidents, however, systems and mechanisms can be changed to reduce future accidents from happening.

Medicine can take a lesson from the aviation industry. Do physicians and other health care providers report near misses? How can we? Where is the incentive? An example: a patient is given the wrong medication or the wrong dose of a medication. No harm results from the incident. Yet, the patient dies of another event a few days later. This creates a tremendous disincentive for reporting the earlier incident. With our litigious society, every effort will be made to blame that patient's death on the first error. There is a punitive atmosphere that encourages nonreporting of near misses. There's even less incentive for decreasing adverse events.

Every physician, every nurse, and every administrator strives to reduce adverse events in and out of hospitals. But we do need to develop a nonpunitive climate to make our system better. It is not the number of errors that occur but the punitive attitude that pervades our society that is the detriment to the cure.

Another lesson we should learn from the aviation industry concerns checklists. Pilots, before takeoff, must review a checklist that contains the most important components. Pilots concentrate only on the most important material.

Have you seen hospital charts lately? They are filled with extraneous materials and pages, diluting the most important notations. Attention should be paid to clarifying the charts and records of our patients so providers can easily review the most important components.

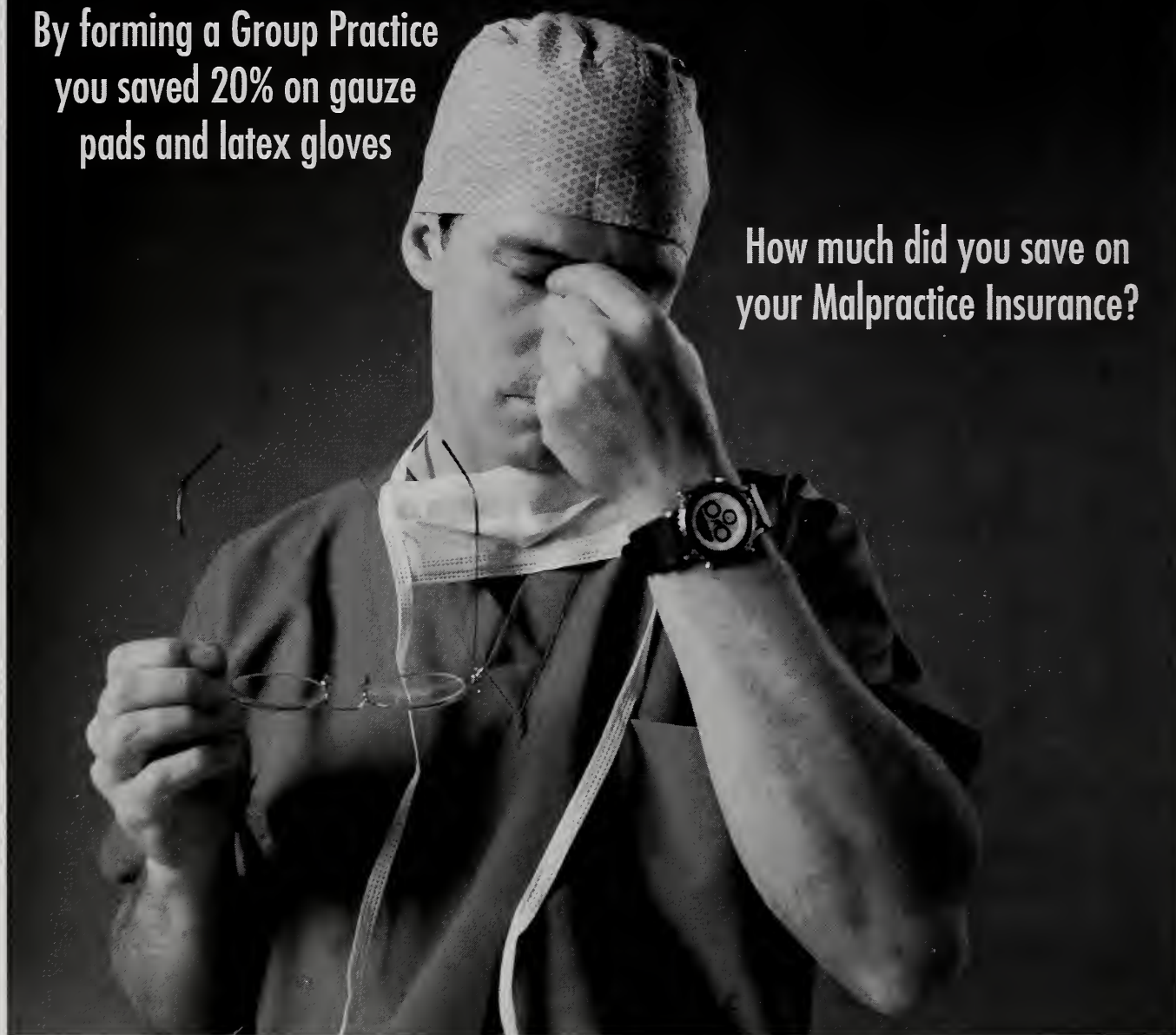
Reporting near misses to reduce human error. Reorganizing charts to reflect essential information. Physicians can learn a lot from pilots.



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# William Augustus Newell

## Physician, Congressman, Governor

Henry H. Sherk, MD

On the afternoon of August 30, 1839, the *Count Terasto* was beating northward toward New York in the teeth of a raging Atlantic storm. The ship was driven closer and closer toward the shore and eventually went aground on a sand-bar 300 yards off that infamous stretch of beach just south of Barnegat Inlet on Long Beach Island, New Jersey. The ship began to break apart in the wild surf and the crew and captain called in their terror for help that they knew could never come. They all drowned in the wreck.

They did not know, however, that a lonely walker on the beach heard with horror the screams of the crew on the stricken ship. Straining through the wind, rain, and stinging sand, he saw the ship being broken apart. In the morning, when the storm had ended, the horror was made worse when the bodies of the crew washed ashore. He and others buried all 13 of them in a common grave in Manahawkin.

Ten years in later, in December of 1849, the Scottish ship *Ayrshire* was badly damaged when it went briefly aground in a blizzard just off Absecon Island near what is now Atlantic City. Demasted, rudderless, and leaking badly, it drifted northward to go finally hard aground near Manasquan about 160 yards off the beach. Broadside to the pounding surf in high winds and in a blinding snow-

storm, the ship was doomed and the fate of the 202 human beings on board seemed sealed. In the decade after the wreck of the *Count Terasto*, however, the situation along the New Jersey coast had changed: the newly organized United States Life Saving Service was prepared to face its first major test. A trained crew of rescuers opened one of the eight "life-saving huts" that had been erected by the US government along the New Jersey beaches. The churning breakers precluded the use of boats, and the rescue team decided to use a beach mortar to shoot a line to the ship and haul the passengers and crew to the shore using the newly invented "life car," a covered dory built in Toms River. They used a yoke of oxen to transport their equipment from the hut to a place on the beach opposite the wreck, and on the second try they landed a ball with a line attached on the ship. The crew on board secured the line to the stump of a mast and the life car shuttled between ship and shore, over and through the surf, removing 201 of the crew and passengers. One man who refused to get inside the car disappeared in the surf.

The stark difference in the outcome of these two events resulted from the efforts of the solitary walker on the stormy beach who witnessed the demise of the *Count Terasto*. He was a young physician who had been in practice for only six weeks. The doomed sailors' cries for help, the wreck,



the 13 bodies on the beach, the funeral, and the common grave haunted him throughout his life. In his later years he could only mourn, but as a young man he could take action, and the wreck of the *Count Terasto* impelled him to embark on a career that can only be described as extraordinary.

## NEW JERSEY POLITICAL CAREER

William Augustus Newell was born on September 5, 1817, in Franklin, Ohio to a Freehold Township, Monmouth County, New Jersey family, who had settled in New Jersey in the years before the American Revolution. He attended school in Millstone Township and entered Rutgers College at the age of 15, graduating with a bachelor of arts degree in 1836. After a brief medical apprenticeship in New Brunswick, he entered the University of Pennsylvania School of Medicine, finishing with an MD in 1839, just before that defining experience on Long Beach Island. Although he quickly realized remarkable success in his practice, he felt he could do more if he achieved political office, and after holding minor county positions, he ran for the US Congress and was elected with a small plurality in 1846. His district included the coastline from Sandy Hook southward to Little Egg Harbor. During Dr. Newell's first term, the country was confronted by President James Polk's controversial war with Mexico and the pressing question of the expansion of slavery into newly acquired territories. Despite the distractions of these burning issues, Dr. Newell managed to engage his congressional colleagues' attention on the issue of the numerous fatal wrecks on the New Jersey coast, and in 1848 Congress passed Newell's bill establishing the United States Life Saving Service.

The bill called for the erection of eight "life-saving stations" along this coast, each of which would contain boats, hawsers, beach mortars, rockets, a life car, and other equipment necessary to rescue passengers and crews from shipwrecks off New Jersey. Each station was staffed by teams of volunteers selected from the population of the

**A lonely walker on the beach heard with horror the screams of the crew on the stricken ship.**

local watermen. The men and their equipment passed their first major test in the spectacular rescue from the wreck of the *Ayrshire*. Encouraged, Newell proposed additional congressional appropriations for new stations along the coast of New Jersey and other states as well as funding for the hiring of professional teams of

trained personnel to staff them. Over time, the service increased enormously in size and scope and hundreds of thousands of lives were saved as a result. Eventually, in 1915, the Life Saving Service was combined by Congress with the Revenue Cutter Service and renamed the United States Coast Guard. Dr. Newell's contributions in the area were recognized by the New Jersey State Legislature in an 1896 resolution honoring him as the founder of the Life Saving Service. A similar resolution was passed by the US Congress in the same year.

Achievement of this magnitude might be considered enough for many, but it was only a chapter in the remarkable life of Dr. Newell. At the end of his second congressional term in 1850, he voluntarily gave up his seat to run for the office of governor of New Jersey and was elected in 1856 amid the chaotic politics in pre-Civil War New Jersey by slightly more than 3,000 votes. He served a single term in office in Trenton, then ran for a US Senate seat but lost; in 1864 he ran again for his old congressional post and was reelected for a third term as the representative from his old district. Although Dr. Newell made several more attempts, he was not reelected to another post by New Jersey voters.

The mere recounting of Dr. Newell's political career belies the effect of his involvement during those turbulent years. His reputation was such that he was nominated for the vice presidency of the United States at the 1864 Republican Convention, but he rejected the position, recommending instead the nomination of Andrew Johnson as a border-state politician who would better help Lincoln's chances for reelection. After Lincoln's assassi-

nation, however, Dr. Newell joined the radical branch of the Republican Party. He campaigned hard for the impeachment and removal of Johnson, who was turning out to be less vindictive against the South than that wing of the Republican Party would have liked. Dr. Newell's performance as governor of New Jersey from 1857 to 1860 was mixed. He had developed a consuming interest in agriculture and was elected to the presidency of the New Jersey Agricultural Society in 1859. Under his leadership, this organization was instrumental in the establishment of the New Jersey College of Agriculture and the New Jersey Agriculture Research Station, both in New Brunswick. Governor Newell's stirring speeches against slavery and for the Union helped solidify New Jersey's position as one of the most reliable states for the Union cause early in the Civil War. He also made progress in the common people's struggle with the railroad and canal monopoly (Camden and Amboy/Delaware and Raritan), and he resisted cronyism and corruption in his appointments. On the debit side, he attempted to delay the right to vote for newly naturalized citizens and campaigned for higher tariffs against the best interest of most citizens. His position as governor was seriously compromised when he refused to commute the death sentence of an Irish immigrant who had been convicted of murder by an all-Protestant jury. The press savaged Governor Newell, and an attack was made on his life by an assailant who was never apprehended.

## POLITICAL CAREER IN THE NORTHWEST

When Congressman Newell returned from Washington DC to New Jersey in 1866, his political career seemed ended. The voters did not return him to office, and he resumed his practice of medicine in Allentown, New Jersey. Fourteen years later, Dr. Newell was thunderstruck to receive a letter from

President Rutherford B. Hayes asking him to accept the position of governor of Washington Territory. Dr. Newell accepted and moved with his wife and daughter to the West. He remained there for almost two decades before returning home. After four years as the appointed governor of Washington Territory, he was appointed US Indian Inspector of the Northwest Territories and spent much of his time working with the Indians and Eskimos in Alaska. After holding several other, more minor posts in the Northwest he returned to Allentown in 1898 at the age of 81 and practiced medicine there until his death. Governor Newell's administration in Washington Territory was notable for his campaign for women's suffrage and the even more unique concept at that time that Native Americans also had the right to vote.

## MEDICAL CAREER

Although a governor and congressman, Dr. Newell was at heart a physician, and he relied on his medical practice to make a living when out of office. His medical career had a number of interesting twists and turns. Within a year or two of beginning his practice in Manahawkin he developed tuberculosis. Hemorrhages and debilitation forced him to

**The bill called for the erection of eight "life-saving stations" along this coast, each of which would contain boats and other equipment necessary to rescue passengers and crews from shipwrecks off New Jersey.**

leave the humid marshy seacoast and retire to the Pine Barrens. (It was assumed in those years that the sandy soil in the barrens drained off surface water and made the air drier and healthier.) Dr. Newell lived outdoors or in an open hut for many months. His recovery must have been complete because he lived an active life for many years thereafter, but he resumed his practice in a new location, remaining in or near the barrens in the community of Imlaystown. There he promptly established a somewhat fabulous reputation by performing a surgical reconstruction of a missing eyelid on a patient whose vision was threatened due to its absence. He removed a skin graft from the opposite cheek and sutured it into position over the



exposed eye. The successful procedure was widely reported in the press, and his practice grew rapidly thereafter. One wonders how he did it since general anesthesia was not available until 1846, three years after the surgery was performed.

During Dr. Newell's first congressional term in Washington, he was called on to treat Congressman John Quincy Adams. Adams had served a term as president and was the only president to have subsequently been elected to the Congress. Adams had the further distinction to be the only congressman ever to collapse and die in the congressional chamber while Congress was in session. Dr. Newell was on hand and was recruited on an emergency basis to provide succor to the dying ex-president. His ministrations in this instance were not successful.

During Dr. Newell's final term in office as a congressman (1865-1866) he was called on by President Lincoln to serve as the White House physician. Newell and Lincoln had served together as congressmen in 1847-1848 and had developed a strong bond of friendship. The Newells and Lincolns often dined together at the White House and considered each other close friends. This bond grew stronger when Dr. Newell saved the life of Lincoln's son Tad when he was suffering from typhoid fever.

## CENSURE BY MSNJ

A dark chapter in Newell's professional life was the formal censure he endured at the hands of the ethics committee of the Medical Society of New Jersey. Dr. Newell stood accused by the Burlington County Medical Society of accepting consultations from an "irregular practitioner," in this case, a Thomsonian. Thomsonians were well outside the mainstream of medical practice and were regarded with contempt by the medical establishment. (Censuring various colleagues for this type of activity appears to have been a blood sport in those days and the more prominent the censuree, the better. A similar incident occurred in 1869 when the Camden County Medical Society prevailed upon the MSNJ ethics committee to censure Dr. Samuel Gross and Dr. Joseph Pancoast, both

prominent Philadelphia physicians, for consulting with a homeopath in Haddonfield.) Dr. Newell denied the charges but the ethics committee voted to censure him anyway. It was a heavy blow, and Dr. Newell was glad to leave New Jersey to take up the post of governor of Washington Territory.

## SOLITARY ACT OF HEROISM

That Dr. Newell was dedicated to his profession is illustrated by the following incident. While serving in the Northwest, he was asked to see a patient who had confluent smallpox. Apparently the confluent, encrusted ulcerations and the foul odor had driven away any other potential caregivers. Dr. Newell, however, sat by the patient and did what he could to ease his suffering. When the patient died it was impossible to find anyone to bury him. Dr. Newell, realizing this, prepared the man for burial, built a coffin, saw that the grave was dug, and conducted a graveside service for the solitary victim of that horrible disease. Only one other person was present at the burial. By that time, Dr. Newell was in his own eighth decade of life.

In the end, when there was nothing left for him in Washington (which was by now a state) or Alaska, Dr. Newell returned home, alone, his wife having died while they were in the Northwest. He had no money and had to take up his practice in Allentown NJ to attempt to make a living. He died penniless in 1901. His body was taken to Trenton, where it lay in state in the Capitol before burial.

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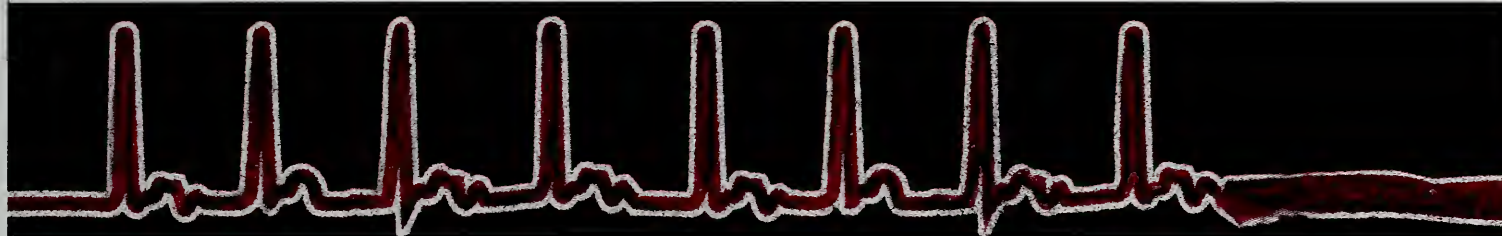
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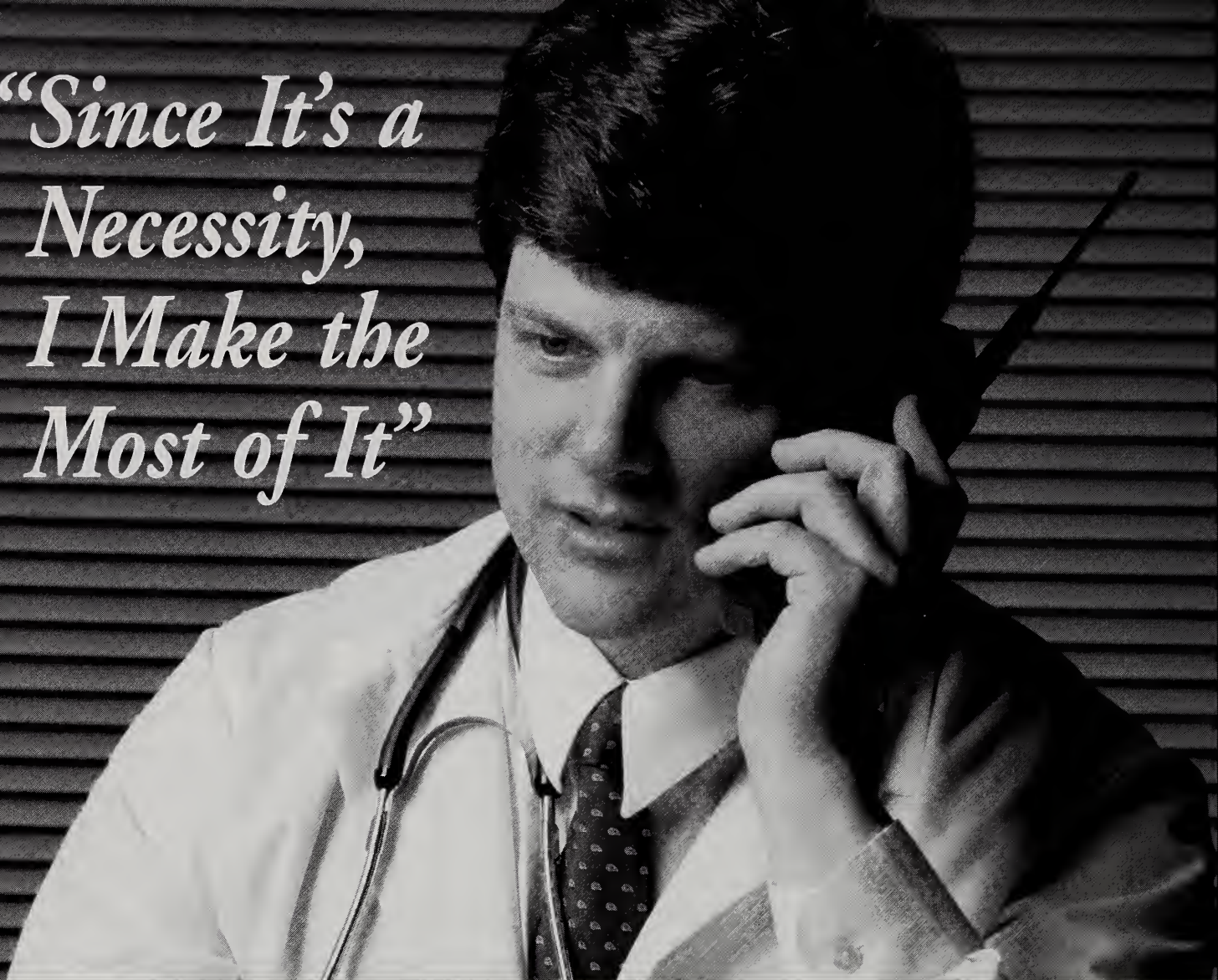
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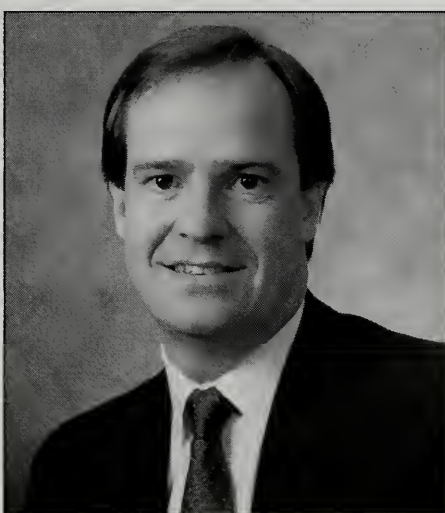
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# Heart Transplantation Services Overdue for Southern New Jersey

*Senator John J. Matheussen*

**A**s vice chairman of the New Jersey Senate Health Committee and longtime advocate of quality health care for all New Jersey residents, I am somewhat troubled by the lack of heart transplantation services in the southern area of our state (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem counties). Over the years I have paid particular attention to the expansion of cardiac procedures such as surgery, catheterization, and angioplasty as well as major organ transplantations, all of which require certificates of need (CN) and licensure in New Jersey. The casual observer can easily visualize a geographic pattern with regard to that expansion, dividing our state into northern, central, and southern regions. Although heart transplantation is offered only in the northern and central regions, kidney, liver, and pancreas transplantations are offered statewide, as are an extensive array of high-quality cardiac services.



*Senator John J. Matheussen*

theory that these procedures should be performed by relatively few hospitals, so as to maintain sufficiently high volume and thus ensure good patient outcomes. I believe that the Certificate of Need Study Commission, in its February 2000 report to the governor and legislature, supports the continuation of that practice. The legislature will in all likelihood act on that study sometime soon.

Undeniably, southern New Jersey has its proportionate share of patients with heart disease, approximately 20.5% of the entire statewide patient population. In 1998, the most recent statistics available, 11% of the 47,115 southern New Jersey residents needing medical treatment for circulatory diseases, which would include all cardiac services, traveled out of state to Pennsylvania for care. Even more significant is the fact that the charge per case for

the 11% that went to Pennsylvania was \$47,295, while in New Jersey the per-case cost was dramatically lower at \$16,509. One can infer from these numbers that Pennsylvania is receiving a disproportionate amount of more intense and costly cases such as cardiac surgery. Although the quality of care provided to patients is and should remain paramount, one cannot ignore the negative job and economic impact on New Jersey health care



providers. We are literally exporting our patients and health care dollars out of state. Giving our southern providers the ability to offer expanded cardiac services, including heart transplant, will help their economic strength and the ability to compete with out-of-state institutions.

The cardiac programs and liver, kidney, and pancreas transplantation services offered in southern New Jersey have gained the respect of physicians and citizens throughout the nation. The volume of procedures performed in the south are in line with the remainder of the state, and the quality of service provided is exemplary. The need to increase our cardiac services to accommodate patients with heart disease already exists. As the population of the region grows and ages, an increasing demand for heart disease management services is a certainty. There is already a sufficient volume of cardiac patients who require heart transplantations, and the vast majority of them are now going to Pennsylvania, not to the central or northern regions of our state. The need for heart transplantation services in southern New Jersey is already here and will only continue to grow with the passage of time.

Providing heart transplantation services in southern New Jersey is not a question of equity but an issue of providing high-quality health care for our residents. It is highly undesirable to outsource the care of heart transplant patients to Pennsylvania or central or northern New Jersey. Health management for these patients involves significant evaluation and treatment

**The need for heart transplantation services in southern New Jersey is already here and will only continue to grow with the passage of time.**

and a high degree of intensity of care with frequent physician visits. Without heart transplantation services in southern New Jersey, these patients are destined to experience a lifetime of excessive travel and inconvenience.

In addition to the likelihood that the legislature will review the CN requirements, DHSS Commissioner Christine Grant has announced that she will be undertaking the develop-

ment of a strategy for cardiac care over the coming five years. This should ultimately result in the form of a report, outlining expected transformations in the configuration of hospital-based cardiac services. This vision should form the basis of the department's adoption of revised CN rules governing cardiac services in early 2001.

The legislature and the department, through the leadership of Commissioner Grant, should work together with the entire health care provider network in formulating a policy that will expand cardiac services and make available heart transplantation in southern New Jersey. Banking on the wealth of experience with other transplant services offered and combining it with the expertise of our fine cardiac care providers, we can and should make heart transplant a reality throughout the state. Our residents—our neighbors, our families, our friends—deserve no less. The time to offer heart transplantation services in southern New Jersey is now.

*John J. Matheussen is assistant majority leader in the New Jersey Senate and senator from the fourth legislative district, which comprises parts of Gloucester and Camden counties.*

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# Introduction to Clinical Positron Emission Tomography

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POSITRON EMISSION TOMOGRAPHY (PET) SCANNING WITH [ $^{18}\text{F}$ ] FLUORODEOXYGLUCOSE (FDG) HAS DEVELOPED OVER 25 YEARS INTO A VALUABLE CLINICAL TOOL USED MAINLY FOR THE EVALUATION OF ONCOLOGY PATIENTS. THE PURPOSE OF THIS ARTICLE IS TO PROVIDE AN INTRODUCTION TO THE BASIC SCIENTIFIC CONCEPTS OF FDG-PET IMAGING AS WELL AS TO ILLUSTRATE ITS CLINICAL UTILITY.

*Harry Agress, Jr, MD*

Positron emission tomography, or PET scanning, is rapidly emerging from academia into the more general medical community as a vital tool for imaging whole-body metabolism.<sup>1</sup> This expansion is occurring not only throughout the US but also recently in New Jersey, where PET is most commonly used in the evaluation of cancer patients.

## HOW PET-FDG WORKS

Whole-body PET scans detect areas of malignancy by identifying regions of abnormal metabolism. The most common radiopharmaceutical used today for PET imaging is [ $^{18}\text{F}$ ] fluorodeoxyglucose (FDG),

which competes with glucose for entry into intracellular metabolism. After intracellular phosphorylation, FDG, unlike glucose, does not proceed further in the metabolic pathway but remains within the cell. The uptake of FDG therefore is directly related to the degree of cellular metabolism. Because most cancer cells have significantly increased metabolism, they have increased utilization of glucose and demonstrate increased uptake of FDG.

Unlike most nuclear medicine tracers that use gamma emission for detection, FDG emits positrons (positively charged electrons). These collide with negatively charged elec-

trons to produce two high-energy "coincidence" photons, which are discharged at 180 degrees from each other. The detection of these photons on opposite sides of the body requires sophisticated detectors, which localize literally millions of these annihilation/coincidence events per second. Scanning is performed one hour after intravenous injection of the tracer. Data is collected and processed and, much like MRI, the images created can be visualized in multiple tomographic planes as well as in a three-dimensional rotating cine mode. The production of the tracer itself is also quite complex and expensive. It



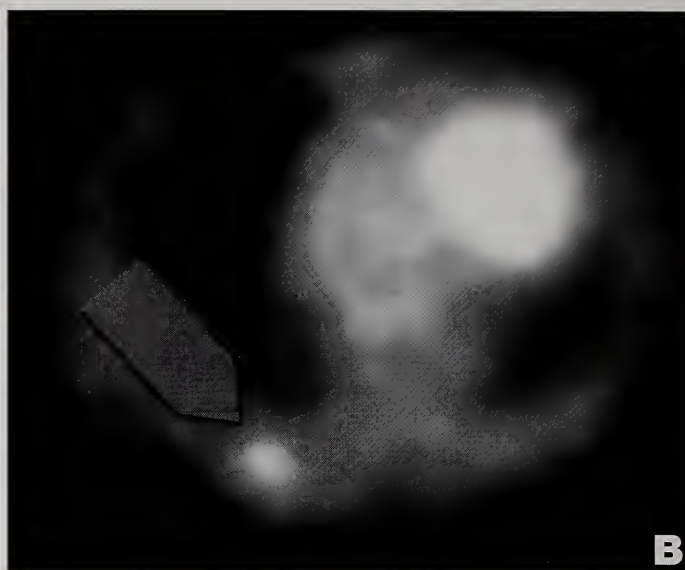
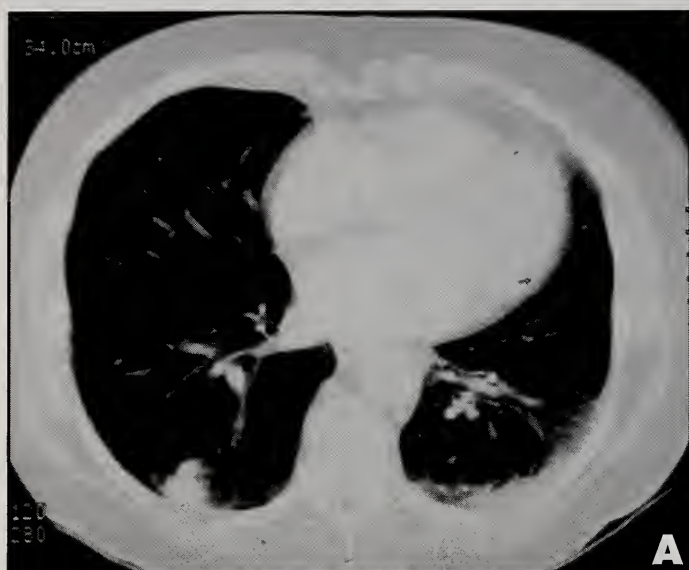


Figure 1. Case No. 1, Solitary pulmonary nodule: (a) CT scan and (b) transaxial FDG scan.

is produced by a cyclotron and because of its short half-life (110 minutes) must be expeditiously transported to remote sites.

There are several detection devices available for PET imaging. The most commonly used in the US is a hybrid detector with advanced electronics adapted to a gamma camera, which allows for both PET coincidence scanning as well as routine nuclear medicine imaging. The other frequently used device, called a dedicated PET scanner, has been used in academic institutions for many years. It has higher image resolution for detection of smaller lesions and is significantly more expensive than the hybrid detector. Dedicated PET scanners have just recently been approved for use in the state of New Jersey.

The relatively new expansion of PET imaging into the more general medical community has occurred mainly as a result of extensive prior research (25 years), the commercial availability of FDG, and recent Health Care Financing Admini-

stration (HCFA) reimbursement for several major oncology indications.

FDG-PET imaging is most commonly used as a problem-solving procedure following more standard imaging modalities, such as computer tomography (CT) and magnetic resonance imaging (MRI). CT and MRI scans use X-ray and electromagnetic energy, respectively, to provide extremely valuable and detailed anatomic information in the diagnosis and evaluation of oncology patients. Frequently, however, there may be difficulty in determining on the basis of size or configuration alone whether a soft tissue mass or prominent lymph node seen with these modalities is malignant or benign. Such a distinction often requires repeated follow-up scans over many months to determine any change. The addition of FDG-PET scans in the evaluation of lesions will in most cases determine whether or not cancer is present.

FDG-PET scanning has been approved by HCFA and many insurance carriers for the evaluation of solitary pulmonary nodules, for the staging of non-small cell lung carcinoma,<sup>3-6,20</sup> recurrent lymphoma,<sup>7</sup> recurrent colon carcinoma (i.e., rising carcinoembryonic antigen with a normal CT scan),<sup>8-10</sup> and recurrent melanoma.<sup>11,12</sup> Other cancers, which are also currently being considered for reimbursement, are head and neck tumors,<sup>13,14</sup> esophageal and gastric carcinomas,<sup>2,15,16</sup> advanced breast and pancreatic carcinomas, soft tissue sarcomas,<sup>2</sup> and carcinoma of unknown primary.<sup>17-19</sup> PET scanning is also valuable in differentiating radiation fibrosis on CT or MRI from recurrent or residual tumor in the chest, abdomen, or brain and in determining the most appropriate (i.e., most metabolically active) site for biopsy within a problematic lesion. It may also be useful in determining early response or lack of response to therapy, consequently altering treatment protocols.

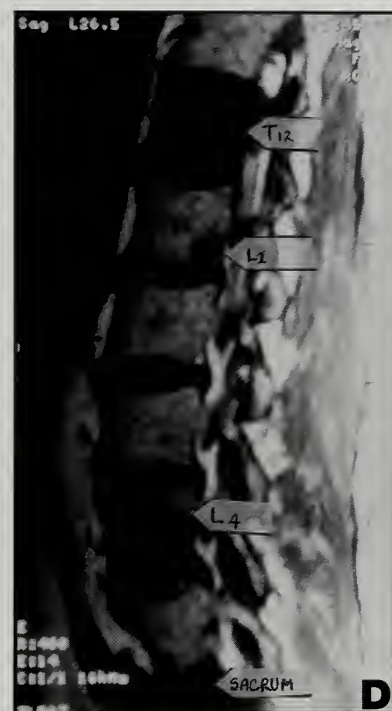
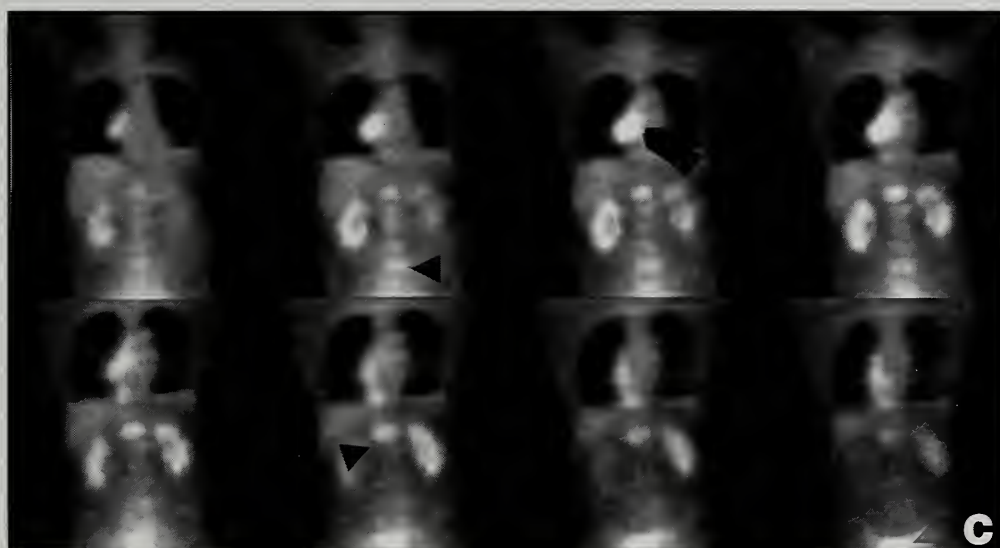
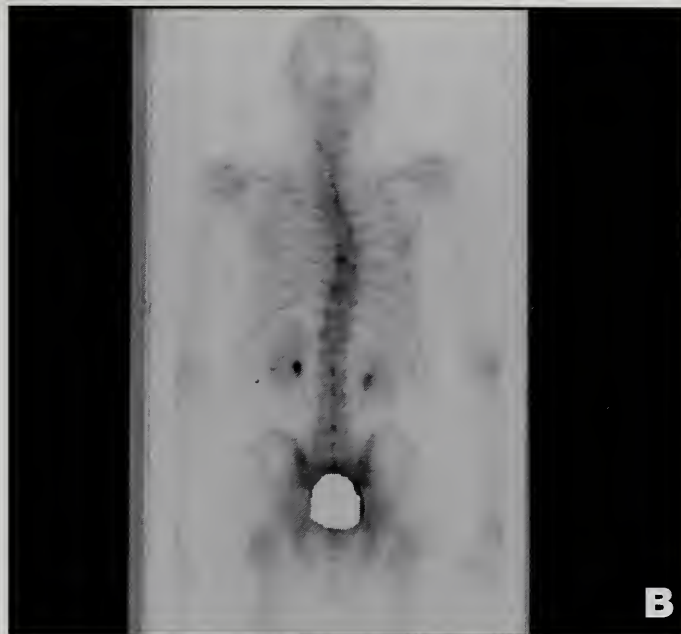


Figure 2. Case No. 2, Lung carcinoma staging: (a) CT scan, (b) Tc-MDP whole-body bone scan, (c) coronal tomographic sections of FDG scan (renal activity represents normal excretion), and (d) MRI of lumbar and lower thoracic spine.

Since the whole body is often scanned, unexpected metastases can be identified.

### EXAMPLE CASES OF APPROPRIATE FDG SCANS

At Hackensack University Medical Center (HUMC), all cases are evaluated for clinical appropriateness before scheduling and all FDG scans are correlated with the prior CT or MRI scan. This has allowed us to have maximum impact on patient

therapy. We have also identified numerous cases in which subtle CT findings, previously dismissed or felt not to be clinically significant, were subsequently shown to represent malignancy on FDG. The scans at HUMC were performed with an ADAC Molecular Coincidence Detection/Attenuation Correction (MCD/AC) hybrid scanner. This correction factor significantly improves image quality by using an

external transmission source to adjust each scan for individual patient size and body contour.

Case No. 1 represents a 73-year-old female with a 1.5cm opacity incidentally noted in the right lower lobe on a chest CT scan (see Figure 1[a]). Biopsy attempts yielded no definite malignancy. An FDG metabolic scan (MCD/AC) demonstrates hypermetabolism within the lesion (arrow in Figure 1[b]). Intense car-



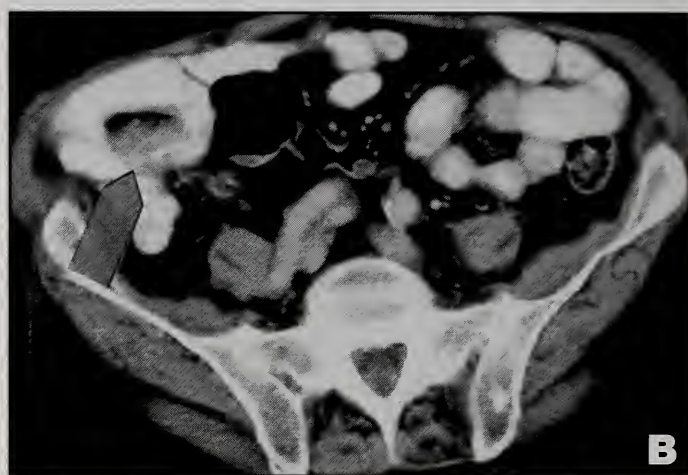


Figure 3. Case No. 3, Carcinoma of unknown primary: (a) coronal FDG scan and (b) CT scan.

diac activity represents a normal variant. Follow-up lobectomy yielded adenocarcinoma.

The sensitivity and specificity of FDG in solitary pulmonary nodule determination of malignancy are 92% and 90%, respectively, in one study<sup>3</sup> and 97% and 89%, respectively, (overall accuracy=92%) in another.<sup>5</sup> In addition, the whole body may be examined to determine extent of disease. False positive results may occur in active granulomatous disease such as tuberculosis, coccidiomycosis, histoplasmosis, and

aspergillosis, as well as acute lung abscess and infected consolidation. False negative examinations have been reported with bronchoalveolar carcinoma and carcinoid and in lesions smaller than 1cm.

Case No. 2 represents a 60-year-old male with fever, cough, and infiltrate on chest X ray. Follow-up CT demonstrated a large right hilar/mediastinal mass with postobstructive pneumonitis (see arrow in Figure 2[a]). Subsequent biopsy demonstrated a bronchogenic carcinoma. A routine technetium-

methylene diphosphonate (Tc-MDP) whole-body bone scan showed nonspecific thoracic activity and no significant abnormal activity in the lower thoracic and lumbar spine (see Figure 2[b]). The patient was subsequently scheduled for adjuvant chemotherapy for tumor reduction before resection. An FDG scan (MCD/AC) was ordered to determine the presence of any unexpected sites of metastatic disease. The FDG scan showed intense hypermetabolism within the lung mass (see arrow in Figure 2[c]), as

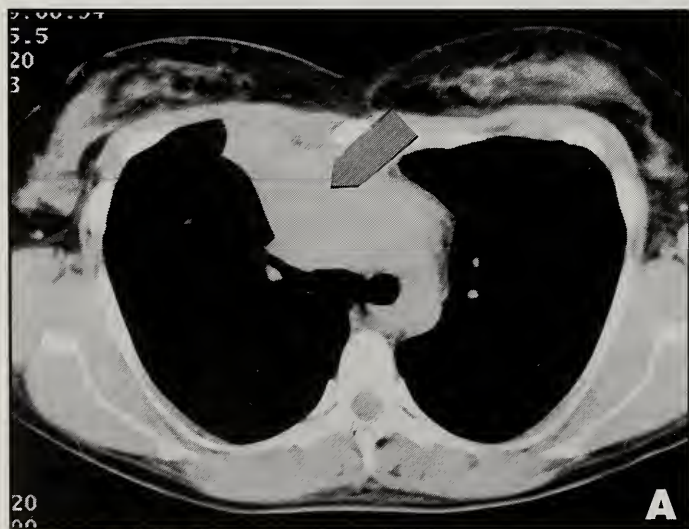


Figure 4. Case No. 4, Lymphoma staging: (a) chest CT scan and (b) transaxial, coronal, and sagittal tomographic sections of FDG scan.

well as multiple foci of hypermetabolism within the lower thoracic and lumbar spine and sacrum (see arrowheads in Figure 2[c]). A follow-up MRI scan (see Figure 2[d]) demonstrated corresponding decreased signal at T12, L1, L4, and the sacrum, representing multiple metastatic lesions, although the patient was asymptomatic in the mid and lower back. As a result, the patient's therapy was appropriately altered and extensive noncurative surgery was avoided.

In staging of non-small cell lung cancer FDG-PET is 92% accurate in diagnosing primary malignancy and is significantly more accurate than CT in staging mediastinal lymph nodes (PET range=85% to 91% versus CT=58% to 64%).<sup>5,20</sup> Distant extrathoracic metastases have been reported in approximately 10% of patients with no evidence of metastatic disease by other imaging modalities.<sup>4,5,20</sup> This emphasizes one of the great advantages of FDG imaging, which is the ability to scan the whole body.

Case No. 3 represents an 86-year-old male with a skin lesion subsequently proven on biopsy to be adenocarcinoma. An outside CT scan of the chest, abdomen, and pelvis was reported as negative for tumor/adenopathy. An FDG scan (MCD/AC) (see Figure 3[a]) demonstrates an intense focus of hypermetabolism in the right lower quadrant (arrow). The cardiac activ-

ity represents a normal variant. Upon review of the outside CT scan, an intraluminal (noncircumferential) density was noted in the cecum (arrow), which was initially interpreted as stool (see Figure 3[b]). A follow-up colonoscopy demonstrated a superficial ulcer with underlying adenocarcinoma of the colon. Approximately 30% to 40% of patients with carcinoma of unknown primary will have positive FDG scans despite negative CT, MRI, and ultrasound examinations.<sup>17,18,19</sup>

Case No. 4 represents a 36-year-old female treated for known Hodgkin's disease. Although a large anterior mediastinal mass had significantly decreased in size on CT scan, a soft tissue opacity persisted (see arrow in Figure 4[a]) several months after chemotherapy. It was difficult on CT alone to determine whether this represented residual disease or fibrosis. The FDG scan (MCD/AC) demonstrated no abnormal increased metabolism within the mass, indicating a good response to therapy with only residual fibrosis (see Figure 4[b]). Initial studies in staging lymphomas indicate a significantly higher sensitivity for FDG scanning when compared with CT (FDG=78% to 100% versus CT=50% to 80% ranges in a multicenter trial).<sup>7</sup>

## OTHER FDG IMAGING APPLICATIONS

Although the focus of this article is on oncologic applications, FDG

imaging has also been used in several other medical specialties. It is frequently used as the "gold standard" for determining myocardial viability (i.e., the degree of hibernating myocardium) within cardiac perfusion defects in patients with previous infarction. FDG is helpful in predicting improvement in left ventricular function following revascularization procedures. FDG scanning is also being used for the determination of the presence and extent of various neuropsychiatric disorders such as Alzheimer's and multiinfarct dementias as well as epilepsy evaluation. More advanced applications will also arise with the development of newer positron-emitting tracers.

In summary, FDG metabolic imaging is an exciting clinical tool for the evaluation of patients with cancer as well as those with selected cardiac and neuropsychiatric diseases. In the initial experience of more than 350 cases at Hackensack University Medical Center, FDG imaging has taken on a significant role in detection and staging of malignancy. It has become an integral part of therapeutic follow-up and clarification of complex or indeterminate findings on CT and MRI. FDG imaging is well beyond the developmental stages. However, it must be used appropriately in conjunction with currently accepted imaging modalities and within



sound protocols. The challenge for proper PET imaging utilization requires joint interdisciplinary involvement of physicians in medicine, surgery, radiology, nuclear medicine, and radiation oncology to provide the most advanced and appropriate use of this rapidly expanding technology.

## ACKNOWLEDGMENTS

The author would like to thank Michael Petrenko, Robert Russo, Helen Chimel, Richard Gentile, Jorge Nuviola, and the Hackensack Radiology Group, PA, for their outstanding support, expertise, and cooperation in coordinating the FDG Imaging Program at Hackensack University Medical Center.

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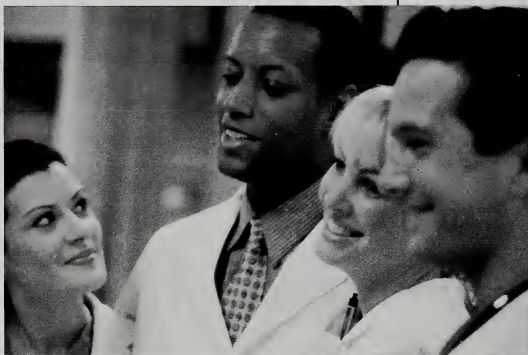
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# HIV Resistance Testing: A New Clinical Tool

DRUG RESISTANCE THREATENS TO ERASE THE RECENT GAINS MADE IN TREATING HIV INFECTION. HIV RESISTANCE TESTING OFFERS CLINICIANS THE ABILITY TO SCREEN PATIENTS FOR RESISTANT STRAINS AND ADJUST TREATMENT ACCORDINGLY. RESISTANCE TESTING IS RECOMMENDED FOR PATIENTS ON ANTIRETROVIRAL AGENTS WITH VIROLOGIC FAILURE OR WITH SUBOPTIMAL SUPPRESSION OF VIRAL LOAD AFTER INITIATION OF ANTIRETROVIRAL THERAPY. BECAUSE OF THE POTENTIAL TRANSMISSION OF RESISTANT STRAINS, TESTING SHOULD BE CONSIDERED FOR PATIENTS WITH ACUTE INFECTION. ALTHOUGH THE CARE OF MANY AIDS PATIENTS IS COMPLEX AND SHOULD BE MANAGED BY A PHYSICIAN WITH EXPERIENCE AND EXPERTISE IN HIV DISEASE, ALL PRACTITIONERS SHOULD BE FAMILIAR WITH THE TYPES OF TESTING AVAILABLE AND THEIR LIMITATIONS.

*Victor S.B. Jorden, MD, MPH and Sindy M. Paul, MD, MPH*

The advent of highly active antiretroviral therapy brought hope to a field in which there was previously very little. The development of new classes of drugs, the refinement of older classes, and an improved understanding of pharmacokinetics and adherence issues have all combined to enhance both the life span and the quality of life for many individuals infected with human immunodeficiency virus (HIV). However, all the progress that has been made with pharmacology can easily be erased by a single naturally occurring phenomenon: drug resistance.

Resistance is hardly a new issue in the management of infectious diseases. Practically since the onset of the antibiotic era, clinicians have worked to meet the challenge of eradicating infections in the face of rapidly developing drug resistance among pathogens. The precise incidence of drug resistance among patients with HIV, whether in New Jersey or nationally, cannot be estimated, because population-based studies have not yet been performed. However, several small studies conducted recently have identified an alarming prevalence of drug resistance among treatment-naïve HIV-positive patients; in one

analysis, prevalence was as high as 26%.<sup>1-4</sup> As expressed in an editorial in *HIV Newsline*, "the prevalence of this disturbing phenomenon (HIV drug resistance) is plainly on the increase."<sup>5</sup> Resistance has been documented to develop against any one of the currently approved HIV antiretroviral agents. Strains resistant to multiple drugs have also been identified.

By understanding and anticipating resistance patterns for a given set of circumstances, physicians have often successfully avoided the administration of useless drugs. However, a more scientific and effective approach has been to



define a pathogen's drug susceptibilities for each individual patient. Unfortunately for patients infected with HIV, resistance testing has not been available until now. As a result, HIV-infected patients with treatment failures attributed to drug resistance have classically been treated empirically, usually by altering the entire drug regimen.<sup>6</sup> This drastic measure has been necessary even if the virus is resistant to only one drug of the regimen, since identifying the useless drug has been impossible.

Two recent prospective investigations support the role of resistance testing in clinical practice. The European Viradapt study as well as the US Genotypic Antiretroviral Resistance Testing (GART) pilot study compared the virologic response to antiretroviral therapy with and without the availability of genotypic resistance testing. The results of both studies demonstrated that guiding antiretroviral therapy with resistance testing resulted in a significantly lower viral load, as compared with clinical judgment alone.<sup>7,8</sup> Similar findings of the advantage of resistance testing using a phenotypic assay versus clinical judgment alone were found in a prospective multicenter study.<sup>9</sup> These benefits were conferred despite the difficulties and inconsistencies in the interpretation of resistance assays.

**Several small studies conducted recently have identified an alarming prevalence of drug resistance among treatment-naive HIV-positive patients.**

Clearly, a new era for treatment of HIV has arrived. As a result of recent technological refinements and supporting evidence from clinical trials, resistance testing for HIV is now a clinical reality. Furthermore, reliable resistance testing will tremendously facilitate research into the epidemiology of the transmission of highly resistant strains, an alarming and perhaps growing component of the AIDS epidemic.<sup>10</sup> This article reviews the basic biology of HIV drug resistance, the techniques used to identify resistance, and the current utility of these techniques. The use of resistance testing in surveillance for resistant strains in New Jersey will also be discussed.

**BASIC BIOLOGY OF RESISTANCE**

Resistance may be defined as the natural ability of a microorganism to withstand the effects of a drug that are lethal to most members of its

species.<sup>11</sup> Host and pharmacological factors, such as persistently subtherapeutic levels of a drug, may play a role in the evolution of HIV resistance to antiretroviral agents. However, the most significant contributors to the development of resistance are those factors related to the virus itself.

HIV is a retrovirus with a profound ability to reproduce its genetic material, a process called replication. An active HIV infection in a typical patient may produce as many as 10 billion new virions in a 24-hour period.<sup>12</sup> However, not every replicated virion will have a genetic pattern identical to its precursor, because the reverse transcriptase gene responsible for the replication is known to make frequent errors.<sup>13</sup> The results of these errors in transcription are mutations of the original genome. The rapid viral replication rate, combined with the relatively low fidelity of reverse transcriptase in making genetically correct copies, results in practically every possible mutation of the HIV genome on a daily basis. If the mutation occurs on a part of the gene that codes for an enzyme targeted by antiretroviral medication (i.e., a critical protease), the abnormal protease enzyme that results from the mutation may have a new structure or conformation that makes it resistant to protease inhibitors.

Not only may multiple resistant mutations be formed on a daily basis, but several mutant strains may also coexist in the same patient. HIV infections are polymorphic: every patient's viral profile consists of several viral strains, reproducing at various rates in a given patient at the same time. The multiple strains may be transmitted to the patient at the original time of infection; these are referred to as primary mutations. Alternatively, resistant mutant strains may develop as a result of faulty replication after the original infection; these mutations are referred to as secondary mutations. Both scenarios may contribute to treatment failure.

Not every mutant strain, whether primary or secondary, will survive. Many mutations will lack the necessary biologic characteristics to subsist, while other strains will have growth and survival capabilities exceeding that of the average strain.<sup>14</sup> The predominant, fast-growing strain is called the "wild-type" strain. However, even if one wild-type strain becomes the principal virus found in the body, other strains may still circulate in very low and virtually unmeasurable concentrations. Furthermore, resistant strains may "hibernate" in lymphoid tissue or other reservoirs within the body. Should the wild-type moiety be successfully attacked by antiretroviral agents, the previously obscure

drug-resistant strain may quickly multiply to become the predominant strain, since it is not susceptible to the effects of the therapy with which the patient has been treated. This phenomenon is known as emergence under selective drug pressure.

### RESISTANCE TESTING TECHNIQUES

The goal of resistance testing is to identify which drugs will be helpful in controlling HIV infection. The two types of resistance testing are genotypic, in which the patient's HIV genome is defined, and phenotypic, in which the actual HIV virus from the patient is subjected to varying medications and its growth characteristics studied.

#### Genotypic Testing

Genotypic testing uses sample HIV from the patient and, through polymerase chain reaction or other

technologies, examines for the presence of mutations on various parts of the genome. The analysis is generally confined to the specific areas of the gene (codons) representing proteins where antiretroviral medications are known to exert their action, such as the various proteases. The patient's genetic material is compared with known mutation patterns that have been recognized as correlating with specific patterns of resistance. Thus, if an individual patient's HIV genome has a pattern associated with resistance to a specific antiretroviral agent, that drug may be purposely avoided in therapy. Genotypic assays can be performed relatively rapidly, such that results can be reported within one to two weeks of sample collection.<sup>15</sup>

The most serious problem associated with genotypic testing is interpretation. The genomes of measurable HIV strains are first defined and then compared with known genomic templates that are related to drug resistance. Unfortunately, the resistance patterns associated with all possible single mutations have not been identified, which is not surprising considering that the HIV genome contains 9,200 nucleotides. In addition, multiple mutations may appear on a single genome, complicating interpretation of known resistance patterns, since a mutation in one part of the genome may suppress or even obvi-

**HIV-infected patients with treatment failures attributed to drug resistance have classically been treated empirically, usually by altering the entire drug regimen.**



ate the effect of a mutation in another part of the genome.<sup>16,17</sup> Finally, a recent study examining the interpretation of standardized HIV genomes in different laboratories revealed significant interlaboratory differences, indicating that even for known mutation-induced resistance patterns, not all experts are in agreement.<sup>18</sup> As stated in a *Lancet* editorial, "the Achilles heel of the (genotypic) technique is interpretability."<sup>19</sup> Interpretation of test results requires an appreciation of the range of mutations selected for by various antiretroviral agents as well as the potential for cross-resistance to other drugs conferred by some of those mutations. Consultation with an expert in HIV drug resistance is encouraged to facilitate interpretation of genotypic results.<sup>15</sup>

### Phenotypic Testing

Phenotypic testing determines the ability of the patient's pathogen, in this case HIV, to grow when subjected to various medications. The virus is grown in culture using peripheral blood mononuclear cells or similar media, after which it is mixed with differing concentrations of antiretroviral agents. Viral growth is then examined, leading in turn to calculations of inhibitory concentrations, such as IC<sub>50</sub> and IC<sub>90</sub>. This type of testing is routinely performed for bacteria and other human pathogens.<sup>15</sup>

**An active HIV infection in a typical patient may produce as many as 10 billion new virions in a 24-hour period.**

Instead of being subject to the interpretation dilemmas associated with genotypic testing, the results of phenotypic testing are drawn directly from observation of viral growth following exposure to drugs. Accordingly, phenotypic analysis is considered by many to better reflect the true response of HIV to a specific agent. Again, interpretation of test results requires an appreciation of the range of mutations selected for by various antiretroviral agents as well as the potential for cross-resistance to other drugs conferred by some of those mutations. Consultation with an expert in HIV drug resistance is encouraged to facilitate interpretation of phenotypic results.<sup>15</sup>

### Problems Associated with Both Genotypic and Phenotypic Techniques

The most prominent deficiency associated with both modes of testing is lack of comprehensiveness: not all strains within a given patient are examined. Assay techniques test only the most concentrated strains

found in serum. Any strain constituting less than 20% of total circulating virus will essentially be missed. In many acute and subacute infections, drug-susceptible wild-type strains vastly predominate, and this domination means that resistant strains found in small concentrations will not contribute to the results of either genotypic or phenotypic testing. As a result, resistant strains may emerge late in the infection under selective pressure once the nonresistant strains have been treated with a given regimen, even though resistance testing had not originally indicated that the virus may have been resistant to that regimen.

Additional issues include the costs of the procedures (\$400 to \$900) and the time required to attain results (days to weeks); these obstacles are considerably more significant for the phenotypic technique. The lack of uniform quality assurance for all assays, as well as the potential for disagreement between the findings of genotypic and phenotypic testing for the same patient, must also be considered.<sup>15</sup> Notably, neither genotypic nor phenotypic assays have received approval for general use from the Food and Drug Administration (FDA), and this lack of approval may translate into lack of insurance coverage. However, the entire process of FDA assay approval is under review at this time. No case

of laboratory personnel acquiring HIV as a result of either phenotypic or genotypic testing has been described.

## CURRENT UTILITY OF RESISTANCE TESTING

In spite of its limitations, AIDS practitioners and researchers are successfully applying the technique of resistance testing in patient management. Resistance testing is recommended as a useful tool in selecting active drugs when antiretroviral regimens are being changed in the setting of virologic failure and for suboptimal suppression of viral load after initiation of antiretroviral therapy. Because of potential transmission of resistant strains of HIV, resistance testing may be considered for patients with acute infection. These assays are not recommended for chronic HIV infection before initiation of therapy or after discontinuation of medications or for patients with a plasma viral load of less than 1,000 HIV RNA/mL.<sup>15</sup>

There is currently no prospective data to support the use of one type of resistance testing assay over the other (i.e., genotypic versus phenotypic) in different clinical situations. One type of assay is generally recommended per sample; however, in the setting of complex prior treatment history, both assays may provide important and complementary information. Because of faster

turnaround time, the use of a genotypic assay may be preferred for acute HIV.<sup>15</sup> Physicians are encouraged to check with the laboratories of their associated hospitals as well as local commercial laboratories to determine the availability of testing for their own patients.

The utility of resistance testing is not limited to use for individual patients: resistance testing is also a powerful tool for public health surveillance. Information from treatment-naïve patients is being combined with data from clinical trials on the development of resistance during treatment to provide a complete picture of the epidemiology of resistant strains of HIV. The New Jersey Department of Health and Senior Services (NJDHSS), in cooperation with the Centers for Disease Control and Prevention, has

**If an individual patient's HIV genome has a pattern associated with resistance to a specific antiretroviral agent, that drug may be purposely avoided in therapy.**

a surveillance system for resistant strains of HIV at selected publicly funded sites in Newark and Elizabeth. As part of this system, newly infected HIV-positive treatment-naïve patients are interviewed, have their medical records reviewed, and undergo resistance testing to determine trends in primary transmission of resistant strains. NJDHSS is currently planning to expand its surveillance system to include patients recruited through private practitioners. Those interested in participating in the surveillance system may contact the authors at (609) 984-6191.

Although physicians should incorporate resistance testing in the medical management of their patients with HIV disease, the following guidelines should be considered:

- There is no substitute for a thorough treatment history when physicians are considering the components of an antiretroviral treatment regimen.
- No therapeutic decision should be made based on the results of resistance testing alone; virologic failure (as well as patient intolerance, etc.) remains the primary reason for changing regimens, and the entire clinical picture must be considered.
- HIV care is complex and should be supervised by a physician with



expertise and extensive experience treating HIV-infected persons.

Victor S. B. Jorden is a resident in preventive medicine and Sindy M. Paul is medical director, Division of AIDS Prevention and Control, New Jersey Department of Health and Senior Services.

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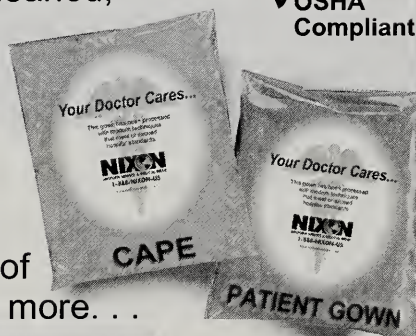
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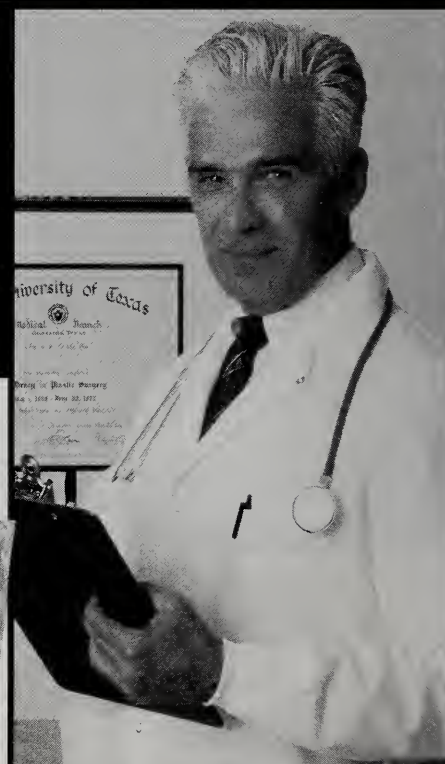
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# The Sharing Network: The First Decade

*Dorian J. Wilson, MD; William Reitsma; Gerry McKeown; Mark Kraljevich; and Carol Pancoska, PhD*

Organ procurement organizations (OPOs) are a work in progress. The complexity and diversity of the system for recovery, allocation, and placement of organs and tissues has required expansion in the responsiveness and capability of the OPO. This evolution has accompanied changes in legislation that have affected the process as well as changes in the communities served by the OPO. The New Jersey Organ and Tissue Sharing Network (the Sharing Network, or TSN), in keeping pace with a changing environment, has continued to grow since its inception in 1987. It has increased the number and diversity of its personnel; strengthened community, hospital, and professional outreach; responded favorably to modifications of transplant legislation; and improved consistently in organ and tissue recovery during the 10-year experience from 1987 to 1997, which is the focus of this article.

## GENESIS

The Sharing Network was created in June 1987 as a result of a merger

of three organ procurement organizations. These organizations were operating independently in New Jersey until that time. They were the Southern New Jersey Organ Procurement Program, a hospital-based program in Camden; the Northern New Jersey Organ Procurement Program, a hospital-based unit located in Newark; and the Transplant Foundation of New Jersey, an independent organ procurement organization based in Livingston. The Sharing Network is organized as a private nonprofit corporation with a board of trustees that represents the community at large.

## ORGAN RECOVERY

Since 1988, TSN has experienced steady annual growth in the recovery of organs and tissues for transplant. Ten consecutive years of increased organ procurement have translated into growth in the number of transplants performed at New Jersey hospitals. During this period, TSN has exhibited a 227% increase in organ donors compared with 34% growth nationally.<sup>1</sup> The total number of

deaths reported to TSN has grown disproportionately to the number of patients referred who are medically suitable for organ donation. The number of patients referred who are medically suitable and brain dead has remained relatively flat for the past five years. In 1993, 573 patients were referred, 196 of whom were suitable as potential organ donors. Five years later, 16,204 patients were referred to TSN, only 245 of whom were suitable to donate organs. The conversion rate (percentage of medically suitable donors where consent is obtained and donation is realized) for the potential organ donors has fluctuated slightly but stayed generally around 50%. It appears that some of the aberrant lows in the conversion rate have a direct correlation with turnover of the transplant coordinator staff, which gives credence to the concept that an experienced transplant coordinator proficient in all aspects of the donor process may be the most qualified person to appeal to the family and offer the option of organ dona-



tion.<sup>2-4</sup> Conversion rates have been between 47% and 55% since 1993.

In contrast to the relatively stable conversion rates, the donor pool has changed dramatically in the past decade. In 1988, only 1% of TSN's organ donor pool was past the age of 50 years. Ten years later, organ donors past the age of 50 accounted for 20% of all donors recovered. Consequently, there has also been a shift in the cause of death of the potential donor referred for organ donation. In 1988, 33% of donors were victims of motor vehicle accidents (MVAs) and only 25% were the result of endogenous cerebrovascu-

**The number of patients referred who are medically suitable and brain dead has remained relatively flat for the past five years.**

lar conditions. In 1997, MVAs accounted for 25% of the donor pool and 46% were cerebrovascular in nature, consistent with the increased incidence of cerebrovascular pathology in the older donor.

Similar trends have been seen nationally.

Unfortunately, the growth in recoveries of organs and transplants performed in New Jersey has been overshadowed by the rapid growth of the transplant waiting lists (see Figures 1 and 2). The New Jersey donor gap has widened throughout this decade, despite a more aggressive approach to transplantation and expanding the donor pool.

## TISSUE RECOVERY

Tissue recovery activity for this 10-year period fluctuated as well. Recent trends have shown significant increases in tissue recovery, particularly in bone, corneas, and heart valves (see Figure 3). Advanced technologies and increasingly successful outcomes have increased the demand for allograft tissue. This increased need necessitated changes within the procurement community to meet this demand. The Sharing Network's increase in tissue recovery is the result of multiple factors. The first factor was a legislative change that required hospitals to report all deaths.<sup>5</sup> Second, TSN implemented a telephone approach protocol specific to the needs arising from TSN's tissue-recovery efforts. The logistics of donation are significantly different for potential organ donors who are brain-dead patients being maintained on a ventilator and potential tissue donors with cardiopulmonary

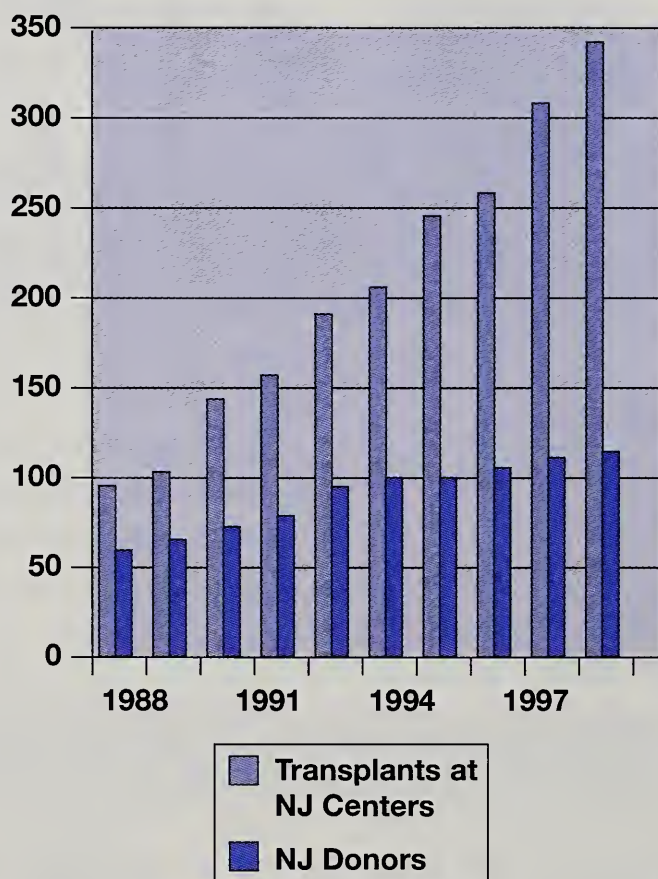


Figure 1. Progressive growth in volume of organ donors and transplants performed at New Jersey transplant centers.

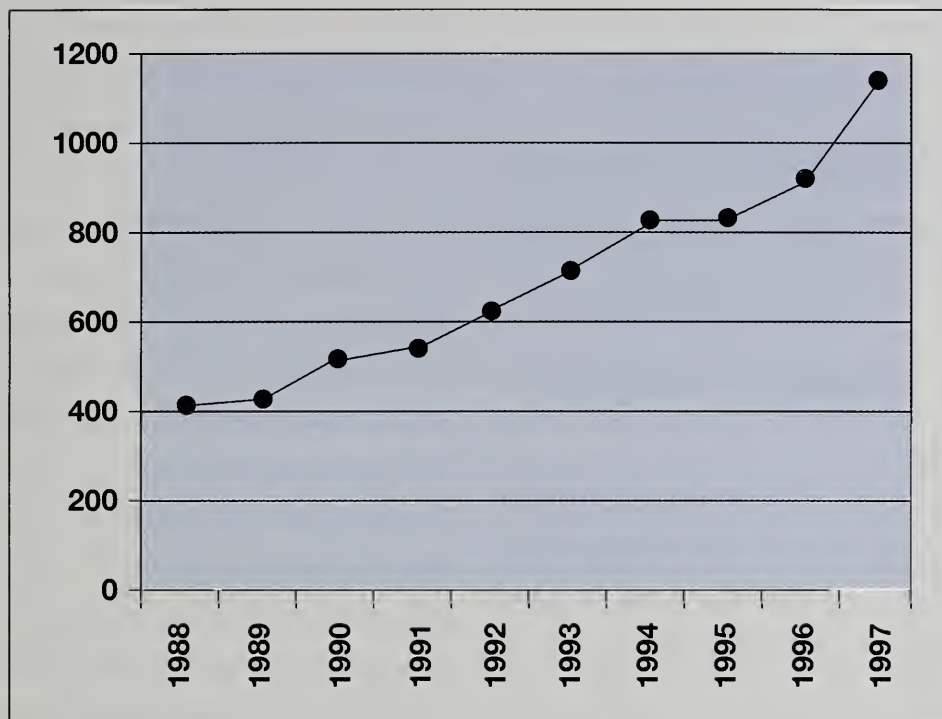


Figure 2. New Jersey potential organ transplant recipients by year.

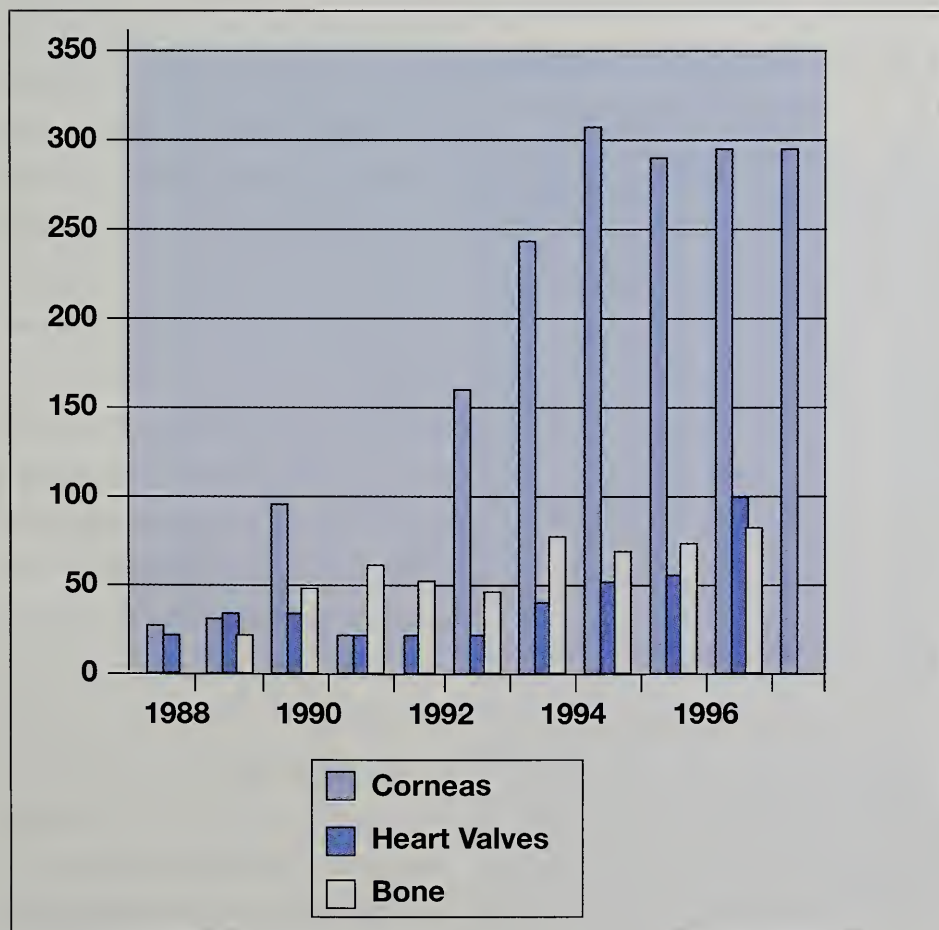


Figure 3. Cornea, bone, and heart valve recovery by year.

death whose families need to be approached expeditiously. These new telephone approach specialists not only have increased the percentage of consents obtained but have also been successful in locating more families within the time constraints when tissue donation is possible. These changes resulted in a profound increase in the number of bone, cornea, heart valve, and skin donors recovered.

## LABORATORY

The Sharing Network's laboratory has undergone tremendous change from the histocompatibility laboratory established in 1988 where five technologists offered basic services to support a renal waiting list of about 400 recipients to the Transplant Laboratory of 1997 with 21 employees on duty around the clock and offering a wide range of laboratory services to the OPO, nine New Jersey transplant programs, and the nearly 1,200 renal and nonrenal recipients on the waiting list in the state. Landmarks in the history of the lab are listed in Table I.

## DEMOGRAPHICS

The Sharing Network functions within what is perhaps the most diverse environment of any OPO in the nation. Its ethnic, religious, and social variability speaks for itself. With a population of more than 8 million residents, New Jersey is the most densely populated state in the



nation with more than 1,042 people per square mile.<sup>6</sup>

## TRANSPLANT LEGISLATION

Transplantation has evolved into a highly sophisticated form of tertiary health care. Legislation has assisted this evolution. The first piece of federal legislation to have an impact on the practice of transplantation was the Uniform Anatomic Gift Act (UAGA) of 1968. The UAGA dealt with several salient issues that provided for the fundamental basis of establishing the legality of organ and tissue donation for transplantation while diminishing the liability for individuals involved in the transplant process.<sup>7</sup> In addition, there was a section addressing who could pronounce death and who could legally recover organs and tissues, as

# The Sharing Network's increase in tissue recovery is the result of multiple factors.

well as a limitation-of-liability clause essentially eliminating liability for anyone who acted in good faith in accordance with the terms of the act. In short, the UAGA set the tone for legal recognition on a national scale of a complex, delicate medical issue.

The Uniform Determination of Death Act of 1980 was written as a model statute intended for adoption in all jurisdictions nationally. It

stated that any individual who had sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem, was dead. Furthermore, the determination of death must be made in accordance with accepted medical standards.<sup>8</sup> New Jersey passed its own Uniform Determination of Death Act in 1991 that included a provision that allowed for a family to raise religious objections to the pronouncement of death by neurological criteria.<sup>9</sup>

By the 1980s, with the success of solid organ transplantation, there was a growing need for greater organization of the national infrastructure, which provided organs for the many potential recipients. In 1984, the National Organ Transplant Act (NOTA) officially began the process that would eventually produce the current comprehensive national health care policy regarding organ transplantation.<sup>10</sup> The most noteworthy effect of NOTA was the creation of the Organ Procurement and Transplantation Network (OPTN), which identified the parameters important for monitoring and tracking the success as well as the deficiencies of the system. Such parameters included the collection of outcome data and the development of a scientific registry. It brought with it a greater awareness of the relatively small percentage of

- 1988 ABO typing, HLA typing, NIH crossmatch, PRA screening by cytotoxicity, ASHI accreditation, and UNOS approval.
- 1989 Antibody identification for additional safety for recipients.
- 1990 Second shift added to accommodate increased volume in the same space.
- 1991 Infectious disease marker screening, leading to reduced testing time for donors.
- 1994 CDC-AHG crossmatch for increased sensitivity and increased safety.
- 1995 All antibody testing converted to CDC-AHG for uniform protocol and increased sensitivity in antibody screening.
- 1996 ACA testing and third shift added; first reference lab contract signed; NY licensed.
- 1997 ELISA antibody screening handles increasing volume with greater reproducibility.

Abbreviations: HLA—human leukocyte antigen; NIH—National Institutes of Health; PRA—panel reactive antibody; ASHI—American Society for Histocompatibility and Immunogenetics; CDC—complement dependent cytotoxicity; AHG—antihuman globulin; ACA—anticardiolipin antibodies; ELISA—enzyme-linked immunosorbent assay; HIV—human immunodeficiency virus; PCR—polymerase chain reaction.

Table 1. Landmarks at the Sharing Network.

potentially transplantable organs that were actually recovered annually for transplantation and the need to increase the supply in light of the growing demand.

The last federal legislative act of major significance is the Omnibus Budget Reconciliation Act. The act was originally written into law in 1985 but included amendments in 1986 and 1987. Broadly, it created requirements for hospitals related to transplantation and organ donation and linked these requirements to federal (Medicare and Medicaid) funding.<sup>11</sup> The law also provided for coverage of immunosuppressive medications to Medicare transplant recipients for a period of one year (recently extended to three years) from the date of transplant. Additional local laws such as the Donor Enhancement Act (1995) in New Jersey dramatically changed hospital participation by requiring referral of potential donors up to 75 years of age. An essential measure of this law also required medical record review of all hospital deaths.

Finally, with the passage of federal laws, New Jersey amended the UAGA in 1986 requiring hospitals to ensure that all families are offered the option to donate (required request), identify a liaison to work with the OPO, and develop policies and procedures that would identify and refer all potential donors.<sup>12</sup> One last set of regulations (specific to

New Jersey) was revised and implemented in 1995 to clarify medicolegal issues related to donation under the jurisdiction of the Office of the Medical Examiner. The revisions require medical examiners to conduct any necessary investigation in such a manner that would not preclude the recovery of any viable organs.<sup>13</sup>

*Dorian J. Wilson is medical director, William Reitsma is vice president and chief operating officer, Gerald McKeown is manager of in-house coordination/data, Mark Kraljevich is team leader, and Carol Pancoska is vice president for laboratory operations at the New Jersey Organ and Tissue Sharing Network, Organ and Tissue Donation Services in Springfield.*

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9. Uniform Determination of Death Act (1991); NJSA 26:6-8.

10. National Organ Transplant Act of 1984, (42 USC Sec 274e).

11. Omnibus Budget Reconciliation Act of 1986, (42 USC Sec 1320b-8).

12. Uniform Anatomical Gift Act (1986); NJSA 26:6-57.

13. State Medical Examiner (1995); NJSA 52:17B-80.

**Transplantation has evolved into a highly sophisticated form of tertiary health care.**



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# Negotiating Effective Managed Care Contracts

Janet A. DelVecchio, MPA

Entering into a contractual agreement with a managed care organization (MCO) can be a frustrating, one-sided experience. Physicians often feel that they have no choice but to accept the contract as offered, which leaves the physician burdened with paperwork and unreasonable conditions. By taking some time before signing an agreement to thoroughly research an MCO and make changes to a contract that are in the best interests of the patients and the practice, the physician can save considerable time and headaches down the road. This article offers a checklist of actions to take before contract signing.

☐ Do some preliminary research:

- Examine the company's financial and strategic strength. Request an annual report and read it thoroughly. It contains a wealth of information

regarding a health plan's stability.

- Inquire about pending and settled litigation, particularly those cases concerning quality assurance and utilization review issues. The plan's recruiter will be able to refer the physician to the appropriate plan representative from whom this information can be obtained.
- Find out whom the plan insures and what the membership mix is. Check membership enrollment and termination statistics.
- Review patient satisfaction survey results.
- Analyze the composition of the provider network. Look at the physician turnover rate as well as the physician/member ratio. The plan's recruiter should be able to quickly supply you with this information.

- Contact federal (e.g., Health Care Finance Administration at [www.hcfa.gov/](http://www.hcfa.gov/)) and state regulatory agencies (e.g., the Department of Banking and Insurance at [www.naic.org/nj/njhomepage.html](http://www.naic.org/nj/njhomepage.html)), regarding any penalties or sanctions assessed to the plan.
- Check with your colleagues; they may possess critical information regarding a plan's performance in terms of claims processing, authorizations and precertifications, and provider services.

- ☐ When you are ready to review the actual contract, the MCO will present you with a template provider agreement and reimbursement schedule. Remember that these are just boilerplates; you can and should negotiate language and provisions that are as favorable as possible to your



practice and that make sense from a quality and a financial perspective.

- ❑ Analyze capitation rates carefully. Look for services (e.g., supplies, drugs, and immunizations) that are carved out of the standard capitation rates. Obtain a written outline of exactly what services are included in capitation. Will a primary care provider be expected to provide pediatric or obstetric/gynecologic services even though it is outside of the norm for that particular provider? It is critical to define the scope of care that you will be expected to provide. Request different capitation rates for different demographic groups. Negotiate a separate fee-for-service rate for high-risk, high-cost plan members.
- ❑ Review a health plan's provider credentialing program to ensure that it is thorough, accurate, and fair.
- ❑ Pay special attention to the indemnification clause in the agreement. This clause stipulates that the physician agrees to indemnify and "hold harmless" the plan for anything that happens as a result of his or her relationship with the plan. A physi-

cian should indemnify a plan only for his or her negligence in the performance of professional services; in other words, what is covered under malpractice insurance. Insist on reciprocal indemnification. Always have your malpractice carrier and your attorney review the indemnification and/or hold-harmless language before signing any contract.

- ❑ It is common to see an amendment clause in a managed care contract. This clause stipulates that the health plan can amend a contract provision at any time. Negotiate a provision that gives you the right to terminate your contract if you disagree with a contract amendment.
- ❑ Examine the health plan's master agreements and member handbooks. Be certain that your proposed contract is not inconsistent with the plan-member contract with respect to covered services and utilization activities.
- ❑ All managed care contracts require physicians to provide services for a specified period of time after the contract is terminated. This allows time for the patients to make a transition to

another provider. A period of 90 to 120 days is reasonable; do not get locked into a longer time frame.

- ❑ Be certain that the contract clearly outlines the posttermination process. For example, the contract should indicate how the following issues will be handled after the agreement has ended:
  - Continuity of care for current patients and appropriate payment to the provider for such.
  - Resolution of outstanding and appealed claims.
  - Resolution of outstanding grievances.
  - How patients will be notified that you are no longer participating with the plan.
  - Payment of any outstanding bonuses, retroactive capitation, or withheld payments.
  - Referral, precertification, and quality assurance requirements for posttermination care of patients.

Using these techniques, you can protect yourself, your practice, and, above all, your patients from the hazards of a poorly written contract. ■

*Janet A. DelVecchio, MPA, is a senior consultant with the MIIX Healthcare Group, Lawrenceville NJ.*

# The Medical Marriage: Sustaining Healthy Relationships For Physicians and Their Families

W.N. Sotile and N.O. Sotile, Revised Edition  
Chicago IL: American Medical Association, 2000  
284 pp., \$25.00  
ISBN: 1579470750

To paraphrase the title of Robert Heinlein's science fiction classic,<sup>1</sup> "medicine is a harsh mistress." In this vein, Michael Myers, MD—who has had extensive experience counseling and treating medical couples—wrote the following in his Foreword to *The Medical Marriage*:

[W]hen I graduated from medical school in 1966, I remember only one professor who made any reference to our lives outside of medicine. His words were, "Marry a strong woman, because she will have to do everything at home—your first duty must be to medicine."<sup>2</sup>

While this sentiment may seem old-fashioned and overblown in today's health care environment of HMOs, physician surplus, physician extenders, alternate health care providers, and younger physicians' desire for a balance between their professional and personal lives, medicine is still a stressful and demanding profession, extending significantly to physicians' marriages.

*The Medical Marriage* is a combination of diagnostic descriptions of problems, psychopathology, and related such issues in physicians' marriages and therapeutic how-to approaches for medical couples in dealing with the stresses and strains

of their medical marriages. The book relies especially on case studies of successful medical marriages. The authors are therapists, not physicians, who have "counseled hundreds of physicians and their loved ones, both individually and as couples; thousands more have given us the privilege of working with them in workshop settings."<sup>3</sup> The book is published by the American Medical Association to ensure wide availability in the medical community.

*The Medical Marriage* is divided into three parts, entitled respectively "Stress, Personality, and Marriage"; "The Basics of Love and Romance: Now and Forever"; and "Medicine, Marriage, and Stress." The first part



discusses the topics listed from the perspective of identifying stressors, characteristic (functional and dysfunctional) ways of responding to these stressors, type-A behavior patterns, and how these concepts play out within a medical marriage. Practical therapeutic techniques, exercises, and strategies for positive behavioral changes are included.

The second part focuses on predictable issues and stressors in marriage generally and in the several phases of premarriage, early marriage, middle marriage, later marriage (this last focusing on empty-nest syndrome), and retirement. The chapters in this part emphasize awareness and planning at all of these phases and suggest practical steps to be taken to ensure as much possible success and intimacy at each phase.

The third part of *The Medical Marriage* returns to discussions of stress, competition, achievement, intimacy, roles and typical role plays (for example, "Pattern 2: The Physician and His Wife: Pleasing Others Even If It Kills Them"), lifestyles, money and finances, and managing aggression and conflict.

The following are sample checklists and questionnaires used in *The Medical Marriage*. They are partial listings only, to give the reader an idea of the material.

## Interpersonal behaviors: When I am overstressed, my interpersonal style tends to be:

- |                                         |                                             |                                                 |
|-----------------------------------------|---------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Argumentative  | <input type="checkbox"/> Controlling        | <input type="checkbox"/> Competitive            |
| <input type="checkbox"/> Defensive      | <input type="checkbox"/> Sarcastic          | <input type="checkbox"/> Act bored              |
| <input type="checkbox"/> Uncooperative  | <input type="checkbox"/> Passive-aggressive | <input type="checkbox"/> Overly sensitive       |
| <input type="checkbox"/> Unaffectionate | <input type="checkbox"/> Needy              | <input type="checkbox"/> Unassertive or passive |
| <input type="checkbox"/> Aggressive     | <input type="checkbox"/> Brusque            | <input type="checkbox"/> Hurried                |
| <input type="checkbox"/> Other _____    |                                             |                                                 |

## Superachiever scale: How do you compare?

Use the following scale to rate yourself on each of the characteristics listed:

- 1 Never
- 2 Sometimes
- 3 Often
- 4 Usually
- 5 Always

|  | How often am I? | How often are you? |
|--|-----------------|--------------------|
|--|-----------------|--------------------|

- |                                            |  |  |
|--------------------------------------------|--|--|
| Time urgent                                |  |  |
| Doing and thinking multiple things at once |  |  |
| Impatient                                  |  |  |
| Perfectionistic                            |  |  |
| Hostile/cynical                            |  |  |
| Controlling                                |  |  |
| Competitive                                |  |  |
| Involved in work                           |  |  |
| Hot-tempered                               |  |  |
| Irritable                                  |  |  |

They emphasize "one key to staying stress-resilient [is to] proactively work to maintain positive, loving connections with each other." The last two chapters of the book ("Managing Anger and Conflict" and "Healthy High-Powered Relationships") have numerous lists, checklists, and exercises about practical ways of dealing with the topics in these chapters (see sidebar for a small sample).

According to the news release about this book by the American Medical Association, *The Medical Marriage* is intended to "help physicians and their families sustain healthy relationships" by "outlin[ing] a proactive approach to making medical marriages and family relationships work successfully" by "teach[ing] how to manage anger and conflict, explain[ing] individual coping patterns, and highlight[ing] traits shared by partners in healthy, positive relationships."<sup>4</sup> As an applied, practical, and behaviorally oriented book, *The Medical Marriage* succeeds in these goals, and I recommend it highly for individuals in what may be considered a traditional, modal, and conservative hetero-

sexual marital relationship, whether of older-generation (50+-year-old) physicians or newer-generation (30- to 50- year-old) physicians.

As the first of two criticisms, in my view, this book does not deal with physicians in alternate lifestyle relationships (e.g., homosexual couples, nonmarried couples, or others). Although individuals in such relationships would undoubtedly constitute a minority of the potential readership for this book, they are nevertheless not discussed at all in the book. My second criticism is that this book is written in a dense, fact- and data-intensive style, which necessarily results in its not being a page-turner. To use this book most effectively, the prospective reader should plan to read it carefully and deliberately and to spend ample time doing so, especially if the reader is not well versed in psychiatry, psychology, behavioral medicine approaches and techniques, counseling, and therapy.

These are my only two criticisms in an otherwise informative, practical, and useful handbook for physicians who want to deal effectively with the health, lives, and problems

of others every day but who also want to deal with their own health, lives, problems, and marital relationships equally well.

**Daniel P. Greenfield, MD, MPH, MS**, is in the private practice of general and forensic psychiatric and addiction medicine in Millburn NJ. He is a clinical faculty member with the Department of Psychiatry at the Albert Einstein College of Medicine/Montefiore Medical Center in the Bronx and the Department of Neuroscience Psychiatry at the Seton Hall University School of Graduate Medical Education/New Jersey Neuroscience Institute at JFK Medical Center, Edison NJ.

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2. Myers M. "Foreword" to Sotile WN and Sotile NO. *The Medical Marriage: Sustaining Healthy Relationships for Physicians and Their Families*, (Chicago: American Medical Association, Revised Edition; 2000, page v).
3. Sotile WN and Sotile NO. *Medical Marriage*. "Introduction," page I.
4. News release, American Medical Association. April 20, 2000.



# Pricing Life:

## Why It's Time for Health Care Rationing

Peter A. Ubel, MD

Cambridge MA: MIT Press, 1999

264 pp., \$25.00

ISBN: 0262210169

We accept drug formularies, utilization review, third-party payment restrictions, capitation, and geographic variations in the rates of surgery. We support organ transplant decisions made partly on the basis of alcohol abuse and other behaviors and copay requirements that persuade patients to avoid necessary as well as unnecessary services. We phase in new medical technologies.

We promote limits on access to antibiotic drugs to prevent resistance and standards of care that take patient characteristics into account. Physicians commonly choose not to contact a health plan to seek an

exception to drug formulary rules or to appeal a medical denial and often save time in patient encounters by avoiding the topics of tobacco, violence, alcohol, advance directives, and seat belts. Adopting a sort of punitive stance, we restrict the availability of treatment and preventive services for people sickened through contraband drug use.

Primary care physicians are judicious in making referrals. Medical organizations (acting against interest) endorse medical savings accounts, which encourage patients, especially less affluent patients, to forgo costly services.

### THE RATIONING WAY

To economists and many or most health policy analysts, these and

other conventions—including price—constitute rationing. To physicians and patient advocates, in general, several or all of these conventions are okay, but rationing is evil. Sometimes, in my experience, physicians go further and try to debunk the entire discipline of economics. What we have in the US health care system is a failure of communication.

Into this breach charges Peter A. Ubel, MD, of the University of Pennsylvania's School of Medicine, Center for Bioethics, and Leonard Davis Institute of Health Economics. In short, Dr. Ubel is a triple threat. His new book, *Pricing Life: Why It's Time for Health Care Rationing*, is the

first in the Basic Bioethics series edited for MIT Press by Glenn McGee and Arthur Caplan. The subtitle is misleading, for rationing, as the author proves, already prevails.

To reach this perspective, Dr. Ubel defines rationing broadly, to encompass any explicit or implicit decision withholding a health care resource that would benefit a patient. He also argues for "bedside rationing," which he views as any clinician's decision to withhold a beneficial service from the patient to save other people's money. He likes bedside rationing, because the alternatives—greater third-party payor power and lumping individual patients under the tyranny of average costs and average benefits—are worse.

Ubel's book is remarkably restrained in the use of economic jargon and will be comprehensible, if provocative, to physicians, other health-related professionals, and educated consumers. The reader will learn diverse ways of calculating the effectiveness in cost-effectiveness

analysis (CEA) and will come to see why benefit-cost analysis improves on CEA (as he defines it) by including nonmedical factors, such as the patient's life expectancy.

Candidly Ubel acknowledges the crude state of CEA. He wants it refined to incorporate such societal values as the "rule of rescue," in which preferences are accorded to the severely ill or others too compromised to help themselves. If anything, Ubel is too deferential to societal choices in the face of a frightening record of inconsistency, innumeracy, sentimentality (including an attraction to identifiable lives and a detachment from statistical lives), and the structural limitations of public opinion research. By contrast, he is condescending to the individual patient, whom he always portrays as the recipient of a decision rather than as someone capable of manipulating the system. (He allocates one line to informed consent in the 183-page book.)

Ubel's work is not a policy brief. There is no analysis of defects in the

allocation of health care resources, and he has no grand proposal for moving toward a better system of allocation. Mainly, this is a text about CEA as applied to health services. The writer waves the banner of rationing at those who wish not to see it. And there the strategy of the book ends. To others, or to later works, is left the task of devising a system that will appeal to people in their protean guises as consumers, patients, taxpayers, voters, health care providers, and payors.

Americans may be uniquely naive about the role of rationing in health care. Seven in eight British physicians were found explicitly to support the rationing of prescription drugs; physicians across the pond have been worn down by a half-century of socialized medicine, where rationing is transparent. But CEA is also here, Ubel concludes, and "for the long haul." All denials to the contrary, rationing is the way of the world.

**Neil E. Weisfeld** is deputy executive director of MSNJ, Lawrenceville NJ.



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## PEOPLE IN THE NEWS

**Dominick J. Eboli, MD**, and **Laura A. Lee, MD**, have joined the trauma team at Capital Health System.

**Russell S. Golkow, MD, MS**, has been named chief of medical imaging at Kennedy Memorial Hospitals-University Medical Center/Cherry Hill.

**Rudolf C. Thompson, MD**, has joined the medical and dental staff of Monmouth Medical Center.



*James E. Gervasoni, Jr., PhD, MD*

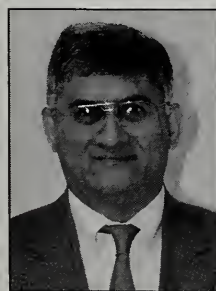
**James E. Gervasoni, Jr., PhD, MD**, has joined Princeton Surgical Associates.

**Robert V.P. Hutter, MD**, chairman of the department of pathology at Saint Barnabas Medical Center, has retired.

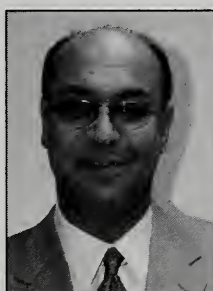


*Riaz Iqbal, MD*

The members of the medical staff at Robert Wood Johnson University Hospital at Hamilton have elected **Riaz Iqbal, MD**, to serve a second term as chief of staff; **Feroz Safdar, MD**, as vice chief of staff; and



*Feroz Safdar, MD*



*Mahmoud Ghusson, MD*

**Mahmoud Ghusson, MD**, to serve a second term as secretary-treasurer.



*Chamain Austin, MD*

**Chamain Austin, MD**, has joined the medical staff in the occupational and



*Angela Bess, MD*

corporate health department of the Robert Wood Johnson University Hospital at Hamilton, and **Angela Bess, MD**, has joined the

medical staff in the department of obstetrics and gynecology. Dr. Bess has also joined the Robert Wood Johnson OB/GYN

Group at Hamilton as a staff physician.

The Monmouth Medical Center has named **Eduardo Delafor Weiss, MD**, codirector of its blood bank. Monmouth also announced that **Frank J. Borao, MD**, **Daniel Hechtman, MD, FACS, FAAP**, **Mihir K. Maniar, DO**, and **Andrew N. Sun, MD**, joined its medical staff. Other staff announcements from Monmouth: **Harriet S. Weinglass, RHIA**, has been named

director of health information management; **Julie Shocksneider, RNC, NP, CNS, MS**, has been named director of training and development; and **Helen N. Rock** has been named clinical director of the Jacqueline M. Wilentz Comprehensive Breast Center.



*Joan F. O'Shea, MD*



*Joseph V. Queenan, MD*



*Eric J. Miller, MD*

**Joan F. O'Shea, MD**, and **Joseph V. Queenan, MD**, have joined the department of neurosurgery at Virtua Memorial Hospital Burlington County and Virtua West Jersey Hospitals. **Eric J. Miller, MD**, medical director of the Breast Evaluation Service at Fox Chase Cancer Center at Virtua Memorial Hospital Burlington County, received the Local Hero Award from the Susan G. Komen Breast

Cancer Foundation and BMW of North America's fourth annual Ultimate Drive for the Cure.

The Commission on Cancer announced the following three-year appointments as cancer liaison



physicians for the hospital cancer program: **Stewart Miller, MD**, at Community Medical Center; **Jan Alice Huston, MD, FACS**, at Saint Barnabas Medical Center; **John Pennacchi, MD**, at Robert Wood Johnson University Hospital at Hamilton; and **Donald McCain, MD**, at Holy Name Hospital.



Maurice P. Coffee, Jr

**Maurice P. Coffee, Jr.**, vice president of government relations for Virtua Health, received the Humanitarian of the Year Award from the Arthritis Foundation's

New Jersey chapter.

**Veronica Thomas, EdD**, coordinator of the Overlook Hospital Crisis Intervention Program, was chosen for inclusion in the 2000 edition of *Who's Who of American Women*.

**Joseph S. Roth**, president and CEO of the New Jersey Organ and Tissue Sharing Network, has been awarded the Association of Organ Procurement Organizations Presidents Award, and **William Reitsma**, vice president and COO, has been awarded the American International Companies Group/Association of Organ Procurement Organizations Excellence in Leadership Award.

#### ACCREDITATION FOR VALLEY HOSPITAL PROGRAM

The Valley Hospital's clinical pastoral education program has

received accreditation from the Association of Clinical Pastoral Education. The program began in 1998 when the Rev. Beth Faulk Glover joined the department of pastoral care. For more information, call (201) 447-8011.

#### EXPANDED MEDICAL IMAGING DIAGNOSTIC CAPABILITIES

The Kennedy Health System has acquired an Infinix VC single plane angiography suite at its hospital in Stratford, which will enable physicians to perform diagnostic and interventional angiographic procedures in the detection and treatment of blocked arteries in major body organs. For more information call (856) 346-7844.

#### MONMOUTH MEDICAL CENTER ANNOUNCES JOINT PROGRAM WITH MOUNT SINAI

Liver disease patients referred to the Recanati/Miller Transplantation Institute at Mount Sinai Hospital and Mount Sinai School of Medicine now have the option of starting their liver transplantation evaluation process at Monmouth Medical Center. Although a majority of the pre- and postevaluations can be done at Monmouth Medical Center, patients need to go to Mount Sinai Hospital for some tests, procedures, consultations, and

surgery. For more information about the program, call (732) 923-9230.

#### VIRTUA HEALTH JOINS WITH NATIONAL UREA CYCLE DISORDERS FOUNDATION ON NEWBORN SCREENING

Virtua Health joined with the National Urea Cycle Disorders Foundation to announce the launch of a comprehensive newborn screening program, offering babies born at Virtua Memorial Hospital Burlington County and Virtua West Jersey Hospital Voorhees an opportunity to be screened for 30 rare but treatable metabolic disorders.

#### KESSLER ACQUIRES MILLERS

Kessler Rehabilitation Corp. has acquired Millers Homecare Services of Hawthorne NJ. Millers will join the Kessler Wilpage Medical division in Livingston in offering home health care equipment and services. For more information, call (888) 992-9705.

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## INTEGRATION OF DATABASES

The integration of the national database of the Society of Thoracic Surgeons (STS) with WebChart Cardiovascular, a tailored version of Data Critical's online patient charting tool, allows cardiac surgeons to give their patients a detailed, evidence-based presurgery risk assessment, helping them understand and weigh the potential risks involved in their surgery. Surgeons also can compare their own outcomes with the national database, and all surgeries charted with the program will automatically go into the STS database, which already contains more than one million heart bypass cases. For more information, call (314) 290-2014 or go to [www.datacritical.com](http://www.datacritical.com) or [www.sts.org](http://www.sts.org).

## MORE WEB SITES FOR HEALTH CARE PROVIDERS

TeleVox Software has launched [www.practiceshowcase.com](http://www.practiceshowcase.com), which offers practices their own Web site hosted on its service. Patients can check their next appointment information online. Practices may also allow patients to view their billing information and can send e-mail newsletters to inform patients of upcoming events or new services. Monthly contracts can be set up for automatic credit card billing and online payment. TeleVox offers additional services for practices as well; for more information call (800) 644-4266 or visit [televox.com](http://televox.com).

## FREE INTERNET SERVICES FOR PHYSICIANS

Free Internet access has been added to MDchoice.com's services for health care professionals

through an agreement with IstUp.com. The free service is targeted to physicians who are not yet online but who are eager to explore the Internet to help them run their practices better. Physicians interested in access must register on the [www.MDchoice.com](http://www.MDchoice.com) Web site. More information is available on the site, or call (908) 203-5200.

## PROVIDERS WANTED FOR INTERNET CASH PROGRAM

MedicalDiscounts.com is a Web site that links consumers paying cash with providers willing to offer cash discounts. Licensed health care businesses and professionals can receive a free listing in the consumer information and referral database by completing the online provider application. For consumers, MedicalDiscounts.com offers medical discount cards without cost, restrictions, or prequalifications. The cards give consumers access to participating health care providers who have agreed to give a discount to people who pay cash at the time of service. The site has consumer health care information that includes estimated discounted prices, a medical quote program, and a health insurance quote program. In addition, there is a prescription program and a loan program for more expensive procedures. For people without access to the Internet, the company offers a toll-free number with Spanish- and English-speaking operators. For more information, go to [www.medicaldiscounts.com](http://www.medicaldiscounts.com) or call (800) 771-3325.

## ONLINE PERSONALIZED SENIOR HOUSING FINDER

MatureMarket.com has announced the launch of a new Internet portal, PersonaMatch.com, which identifies the best housing choices for seniors, based on their geographic preference, physical needs, finances, and other personal preferences. In addition to housing referrals, PersonaMatch also provides an array of online tools and resources to guide families and seniors in the decision-making process of moving. Multiple family members and doctors, nurses, or social workers can collaborate online. It bridges the miles, allowing concerned family members and geriatric professionals to share in the process of finding a senior community. For more information, go to [www.PersonaMatch.com](http://www.PersonaMatch.com), call (972) 248-9250, or e-mail [Press@PersonaMatch.com](mailto:Press@PersonaMatch.com).

## DOCTORS' CLINICAL USE OF WEB STILL LOW

Two back-to-back stories in *Internet Healthcare Strategies* highlighted an ironic trend: while consumers most trust the health Web sites recommended by their doctors, physicians are online, mostly from home and for personal use, only about six hours per week. They spend little time looking for clinical information. On the bright side, however, was the fact that one-third of the physicians polled work in practices with their own Web sites, and that number will no doubt increase rapidly. (A number of Web sites offer doctors Web pages for free—see, for example, <http://www.medscape.com/medscape/homepages/>.)



## E V E N T

## D A T E

## L O C A T I O N

## O c t o b e r 2 0 0 0

|                                                                                 |                       |                                                                 |
|---------------------------------------------------------------------------------|-----------------------|-----------------------------------------------------------------|
| <b>1st International Geriatric Palliative Care Congress</b>                     | October 11-14         | New York NY, (514) 286-0855                                     |
| <b>The Fetus and Newborn: State-of-the-Art Care</b>                             | October 11-14         | Crystal Gateway Marriott, Washington DC, (925) 828-7100         |
| <b>Ophthalmology for the Medical Practitioner</b>                               | October 12            | Baltimore MD, (410) 955-2959                                    |
| <b>Contemporary Nuclear Cardiology</b>                                          | October 12-14         | Heart House, Bethesda MD, (301) 897-2694                        |
| <b>8th Conference on Radioimmuno-detection and Radioimmunotherapy of Cancer</b> | October 12-14         | Princeton NJ, (973) 844-7007                                    |
| <b>Managing Respiratory Diseases</b>                                            | October 13-15         | Marriott Marquis, New York NY, (800) 421-3756                   |
| <b>Cardiovascular Imaging Conference</b>                                        | October 13-15         | Philadelphia PA, (800) 373-2204                                 |
| <b>American College of Gastroenterology</b>                                     | October 13-18         | New York NY, (703) 820-7400                                     |
| <b>Mt. Sinai 2000 Update: Body Imaging</b>                                      | October 14-17         | New York NY, (770) 641-9773                                     |
| <b>MSNJ Board of Trustees Meeting</b>                                           | October 15            | Lawrenceville NJ, (609) 896-1766                                |
| <b>MSNJ Council on Public Health</b>                                            | October 18            | Lawrenceville NJ, (609) 896-1766                                |
| <b>Cardiology for the Noncardiologist</b>                                       | October 21-22         | New York NY, (201) 342-5300                                     |
| <b>American College of Emergency Physicians</b>                                 | October 21-24         | Philadelphia PA, (800) 798-1822                                 |
| <b>Fundamentals in Critical Care Course</b>                                     | October 26-27         | Danville PA, (717) 531-6483                                     |
| <b>American College of Rheumatology</b>                                         | October 28-November 2 | Pennsylvania Convention Center, Philadelphia PA, (404) 633-3777 |

## N o v e m b e r 2 0 0 0

|                                                                                                                      |               |                                                               |
|----------------------------------------------------------------------------------------------------------------------|---------------|---------------------------------------------------------------|
| <b>IMG Dinner Meeting</b>                                                                                            | November 1    | Lawrenceville NJ, (609) 896-1766                              |
| <b>Genetics for the Primary Health Care Provider</b>                                                                 | November 1-3  | Washington DC, (202) 782-2637                                 |
| <b>American Society of Cytopathology</b>                                                                             | November 7-11 | Philadelphia PA, (302) 429-8802                               |
| <b>Chemotherapy Foundation Symposium XVIII</b>                                                                       | November 8-11 | Sheraton New York, New York NY, (212) 241-6772                |
| <b>5th New Jersey Symposium on Biomaterials Science</b>                                                              | November 9-10 | Somerset NJ, (732) 445-0488                                   |
| <b>4th Annual "Companions on the Journey" Conference Exploring Mental Health and the Mind-Body-Spirit Connection</b> | November 15   | New Jersey Hospital Association, Princeton NJ, (609) 396-6590 |

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# CALENDAR

## E V E N T

## D A T E

## L O C A T I O N

### N o v e m b e r 2 0 0 0

|                                                                                                                        |                            |                                                                                             |
|------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------|
| <b>Measuring Health-Related Quality of Clinical Trials</b>                                                             | November 16-17             | New York NY, mbarberan@mapi.fr                                                              |
| <b>Gynecologic Pathology—Approaches to Common Problems with Emphasis on New Entities and Techniques</b>                | November 17-18             | Baltimore MD, (410) 955-2959                                                                |
| <b>Women's Health &amp; Counseling Center and the Resource Center for Women and Their Families Reigning Women Ball</b> | November 18                | Merck & Co. World Headquarters<br>Whitehouse Station NJ, (908) 526-2335                     |
| <b>Research Conference on Research Integrity</b>                                                                       | November 18-20             | Washington DC,<br><a href="http://ori.dhhs.gov/page1.htm">http://ori.dhhs.gov/page1.htm</a> |
| <b>MSNJ Board of Trustees Meeting</b>                                                                                  | November 19                | Lawrenceville NJ, (609) 896-1766                                                            |
| <b>Back Pain and Disability—Unraveling the Puzzle</b>                                                                  | November 30-<br>December 2 | New York Medical Center,<br>New York NY, (800)872-3105                                      |
| <b>Interpretation and Treatment of Cardiac Arrhythmias</b>                                                             | November 30-<br>December 2 | Philadelphia PA, (301) 897-2694                                                             |

### D e c e m b e r 2 0 0 0

|                                                            |                |                                                             |
|------------------------------------------------------------|----------------|-------------------------------------------------------------|
| <b>Clinical Informatics</b>                                | December 1     | Philadelphia PA, (617) 630-1300                             |
| <b>Public Health: CARE Forums Institute Economic Forum</b> | December 6     | Lawrenceville NJ, (609) 896-1766                            |
| <b>Controversies in Obstetrics and Gynecology</b>          | December 6-9   | New York NY, (202) 863-2525                                 |
| <b>Dermatology for the Nondermatologist</b>                | December 15-17 | Grand Hyatt, New York NY,<br>(800) 421-3756                 |
| <b>New York Cardiovascular Symposium</b>                   | December 15-17 | New York NY, (301) 897-2694                                 |
| <b>17th Annual Clinical Update of Pulmonary Disease</b>    | December 16    | Sheraton Atlantic City, Atlantic City NJ,<br>(609) 893-1200 |
| <b>Lower Genital Tract</b>                                 | December 17-20 | Marriott Marquis, New York NY,<br>(215) 542-3838            |
| <b>MSNJ Board of Trustees Meeting</b>                      | December 17    | Lawrenceville NJ, (609) 896-1766                            |
| <b>Public Health: CARE Leadership Coalition</b>            | December 20    | Lawrenceville NJ, (609) 896-1766                            |

### J a n u a r y 2 0 0 1

|                                  |            |                                  |
|----------------------------------|------------|----------------------------------|
| <b>MSNJ Nominating Committee</b> | January 10 | Lawrenceville NJ, (609) 896-1766 |
| <b>Committee on Appointments</b> | January 10 | Lawrenceville NJ, (609) 896-1766 |

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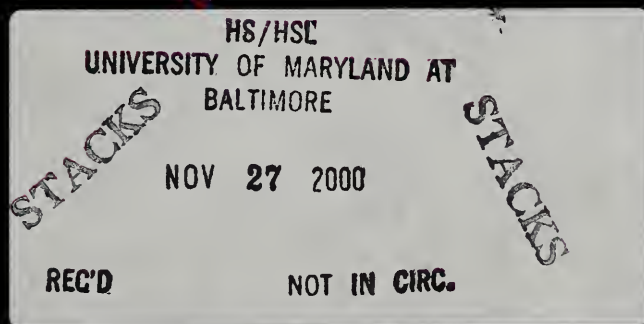
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## Respect, but verify

When Humphrey Taylor's Harris Poll surveyed 1,010 Americans in late summer about their respect for members of 17 occupations, guess which occupation ranked first, ahead of scientists, clergy, military officers, and members of Congress.

Physicians may fear a loss of respect; however, these results show that the profession of medicine remains, in this country, the most prestigious way of making a living.

Still, physicians can't take public support for granted in this cynical, antiauthoritarian information age. Patients believe their physician, but only when the physician is driven by what's best for the patient. Consumers seek out physician services, so long as those services are accessible and differentiated by quality. The public adheres to medical advice that is based on science and isolated from conflicts of interest.

Even with unsurpassed credibility, medical practitioners are vulnerable to resentment. The clinician who keeps secrets from

patients is highly susceptible to malpractice litigation. A doctor who is perceived as self-important or arrogant, who interrupts patients too readily or sidesteps their concerns, is at risk in the medical marketplace.

**Quality of Care.** In New Jersey there's special cause for physicians to act to preserve their justly and carefully acquired reputation. The October release from the Health Care Financing Administration (HCFA) of state-by-state physician performance in 24 indicators of quality of care rendered to Medicare patients shows the Garden State at almost the bottom of the heap, below every other Northeastern state.

To improve physician performance in these indicators, several organizations, including the Medical Society of New Jersey (MSNJ) and its quality-of-care arm, the Medical Review and Accrediting Council, Inc. (MRAC), have formed a leadership team. Practitioners throughout the state will hear regularly about the need to

meet standards of care involving heart attack, breast cancer, diabetes, heart failure, pneumonia, and stroke.

Quality of care also was at issue the following week, when Governor Whitman and Health and Senior Services Commissioner Christine Grant issued the state's annual HMO report card. The

**"Four dysfunctional attitudes or assumptions are prevalent" among health care providers, asserts health care marketing expert Scott MacStravic in an article abstracted in the *Healthcare Leadership Review*. These wrong-headed ideas include the notions that consumers are unable to judge quality of care and that quality-of-life issues don't matter in health care, says the writer.**

Another MacStravic bugaboo is the belief that the episode of care is all-important, masking outcomes. Finally, he criticizes the belief that a hospital or other provider's sole mission is to be a high-quality organization, adorned with credentials, board certifications, and Olympian laurels.

findings show New Jersey HMOs lagging behind other HMOs in the region in quality-of-care indicators, such as mammograms, immunizations, and retinal eye exams for diabetics. Because physicians, not HMO executives, actually provide the care that is at issue, HMO



report cards have strong implications for New Jersey physicians.

Quality concerns certainly are attracting legislative attention. One proposed bill, captioned S-1610 in the state Senate and A-2776 in the Assembly, would set up a commission to explore ways to promote reporting of medical errors. On October 12, Assembly Health and Human Services Committee chair Charlotte Vandervalk (R-Westwood) heeded concerns expressed by MSNJ and others and held the bill in committee, but the issue of mandatory reporting of medical errors could resurface at any time.

## PRESSURES

One regulatory threat to physicians presents in the guise of the federal Emergency Medical Treatment and Active Labor Act (EMTALA). This seemingly benign "antidumping" law prohibits hospital emergency departments from transferring poor or uninsured, medically unstable patients, including women in labor, to hospitals that provide more charity care.

In its current role, though, EMTALA is a wolf dressed up as grandma. (I imagine that statement is politically incorrect on many levels, but bear with me.) Under EMTALA regulations,

HCFA requires on-call physicians to respond promptly and screen and stabilize patients prior to transfer. The AMA has prepared a handy "EMTALA Quick Reference Guide for On-Call Physicians."

## HOTLINE

Troubles with the Medicare carrier? Empire Medical Services has installed a toll-free telephone hot line for physicians, (877) 567-9235.

## OFF LIMITS

In an advisory bulletin, New Jersey's Small Employer Health Insurance Program warns against limits on home health care expressed in days, hours, or dollars. States program deputy executive director Ellen F. DeRosa: "Any carrier found to be imposing a limit on medically necessary and appropriate services for home health care will be considered in knowing violation of New Jersey law."

## TOBACCO FRONT

New Jersey Breathes, the tobacco control coalition convened by MSNJ, urged the state division of taxation to withdraw a proposal to allow cigarette merchants to charge lower prices. Coalition chair Fred M. Jacobs, MD, JD, and MSNJ president Walter J. Kahn, MD, noted the impact of price on youth

smoking rates and observed that the proposal conflicts with state policy to prevent youth smoking. The division withdrew the proposal.

Meanwhile, the Campaign for Tobacco-Free Kids complains that cigarette manufacturers are increasing youth marketing by leaps and bounds. Examples include more advertising in magazines like *Sports Illustrated* and *Glamour* and displays in convenience stores that feature such kid-appealing products as boom boxes. In New Jersey the average age of youth onset smoking is 11.

## RAISE HIGH THE PREMIUMS

Expect big increases in health insurance premiums for several years. A Health System Change *Issue Brief* observes that we've entered the phase of the insurance cycle where insurers forgo market share in order to generate profits.

Experts predict employers will respond by offering fixed contributions to their employees' coverage, rather than a defined benefit package. The analysts note that "only a portion of premium increases is being passed along to providers" and "doctors are in an even tougher spot than hospitals." Too bad you can't put respect in the bank.

Neil E. Weisfeld



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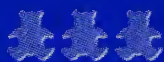


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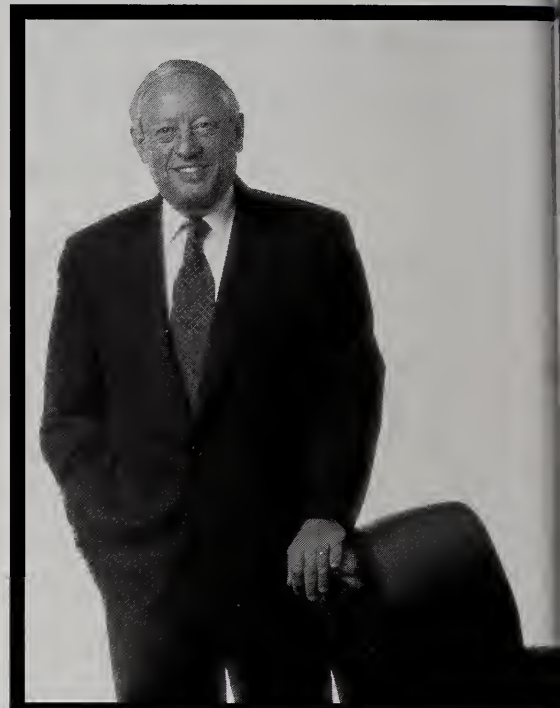
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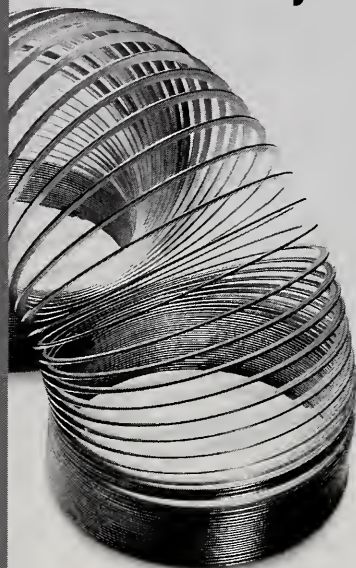
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Merck & Co., Inc. is a New Jersey company that has defined its community as the entire world, and it acts accordingly. One specific and dramatic example is its commitment to the treatment and eradication of river blindness in Africa and South America, through an extraordinarily successful program that the company initiated approximately 13 years ago. Another example is its recent announcement of a partnership for a pilot project to treat and eliminate AIDS in Botswana. In both instances, Merck has donated medicines, funding, personnel, and other

resources to provide access to care and to improve the health of large numbers of patients who otherwise would not receive effective treatment.

In this month's interview with Raymond V. Gilmartin, chairman and CEO of Merck, we discuss these programs and other topics. In the article that immediately follows the interview, Mr. Gilmartin provides additional details about the river blindness and AIDS projects and also discusses prescription coverage under Medicare. Each of these is tied to Merck's corporate vision of access to medicines for everyone.

*New Jersey Medicine* believes that the example set by Merck deserves our notice and comment, and these words of George W. Merck appear prominently on its Web site: "We try never to forget that medicine is for the people. It is not for the profits. The profits follow, and if we have remembered that, they have never failed to appear." This is a laudable philosophy for any company that provides health care or deals with any aspect of medical care.

## A NEW FEATURE FOR *NEW JERSEY MEDICINE*

In this issue we begin a new feature, a guest column that will appear regularly on the back page of *New Jersey Medicine*. Harvey A. Holzberg, the subject of an interview in these pages several months ago, has been invited to provide a regular column for us. He has agreed to do so, on a quarterly basis, for one year.

Mr. Holzberg is president of Robert Wood Johnson University Hospital in New Brunswick, a combined academic institution and community hospital that, as we previously observed, has enhanced both medical care and medical education.

When we published our interview with Mr. Holzberg, we editorially stated that he was "frank, pragmatic, idealistic . . ." He was that and more. His published comments were interesting, provocative, and challenging. We are therefore especially pleased that he has accepted our invitation to write for us. His first column, which discusses our health care system, how it got that way, and where it should be headed, will be of interest to all of our readers.

**Paul J. Hirsch, MD**



## THE HCFA STUDY

A study funded by the Health Care Financing Administration (HCFA) and published by the *Journal of the American Medical Association* found that the quality of health care in New Jersey does not measure up to most of the rest of the country.

The study, which reviewed the care of Medicare patients not enrolled in HMOs, evaluated patients' receipt of 24 "process-of-care" measures related to the treatment or prevention of a variety of medical conditions. Performance measures included mammograms at least every two years, administration of aspirin for heart attack, and flu shots. New Jersey was ranked 48th in the country out of 52 (the 50 states, plus the District of Columbia and Puerto Rico). Data collection involved hospital record abstraction, analysis of Medicare claims, and (for immunization rates) surveys. The authors conclude, with regard to the entire country: "These findings indicate substantial opportunities to improve the care delivered."<sup>1</sup> They call for a partnership among physi-

cians, hospitals, health plans, and purchasers to accomplish that improvement.

HCFA has indicated that it plans to extend and enhance its collection of data to allow it to provide information on national trends every few months and state-by-state estimates every three years.

Dr. Joseph W. Sokolowski, Jr, chairman of MSNJ's Medical Review and Accrediting Council (MRAC), stated in response to the study: "We agree that the data released today indicates systemic problems with care in the state of New Jersey." He is right. We should not waste time being defensive or trying to explain away the study or its findings. We must review the study, identify reasons and causes, correct problems, improve performance, and improve the medical care of the people of New Jersey.

1. Jencks SF et al. Quality of medical care delivered to Medicare beneficiaries. 2000. *JAMA* 284:1670-1676.

## THE STATE OF UMDNJ

We are pleased to be able to present for the readers of *New Jersey Medicine* the "State of the University" speech delivered by Stuart D. Cook, MD, president of the University of Medicine and Dentistry of New Jersey. It is a fitting time to review the accomplishments and recent progress of the university: this month is the second anniversary of Dr. Cook's appointment as president.

The university is one of the great assets of our medical community and of the citizens of New Jersey. It has rapidly grown in stature and in national prominence, consistent with its strategic intent: "The pride of New Jersey today, the pride of the nation tomorrow." In his talk, Dr. Cook out-

lines the five established goals of the university and the advances that have been made toward each. The achievements are significant and noteworthy and should be a source of pride for the university and for all of us involved in the care of patients in New Jersey.

Just a year ago, in an editorial in these pages, we noted that Dr. Cook had stated it was his goal "to accelerate the university's trajectory to greatness." He and the university that he heads have made great progress toward that goal.

**Paul J. Hirsch, MD**

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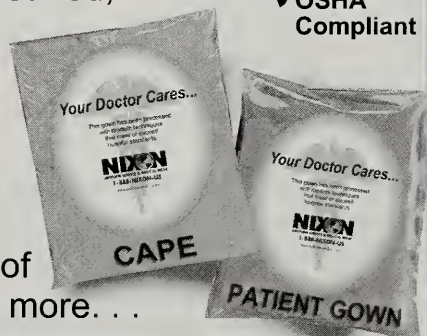
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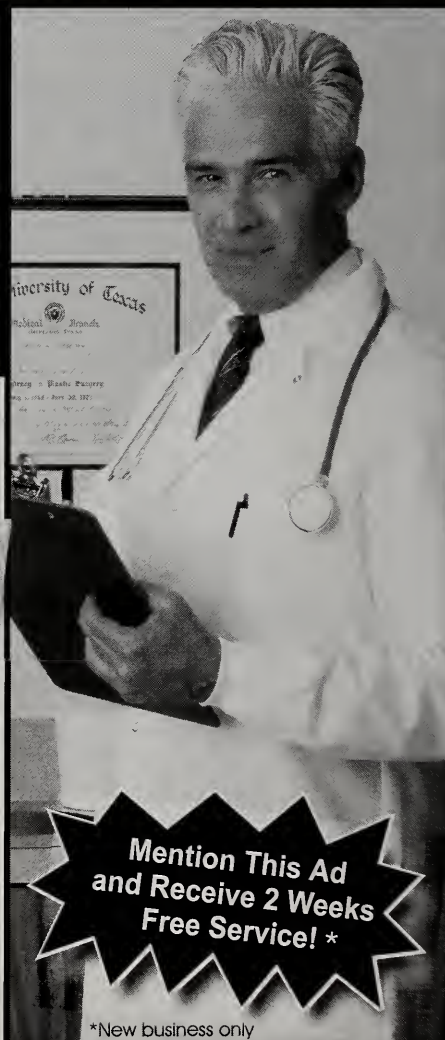


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## YOUTH SMOKING: ONGOING PROBLEM

I was pleased to read the "New Jersey Youth Tobacco Survey," initiated by the New Jersey Department of Health and Senior Services (August 2000). On the other hand, I was disappointed that this work was not compared with two previously published survey articles, which appeared in the *Journal of the Medical Society of New Jersey* in 1966 and *New Jersey Medicine* in 1991, respectively, covering surveys executed in 1965 and 1989.<sup>1</sup>

The earlier surveys each involved about 15,000 Atlantic County students in grades 5 through 12.

Although the 1999 survey was not identical to the earlier investigations (e.g., it was statewide, they were countywide; it covered tobacco use; they covered cigarette use), the overall findings of the three surveys—cost factors, peer pressure, family influence, number of cigarettes smoked, and remedies—were quite similar.

There obviously remains a serious ongoing problem regarding youth tobacco usage. The ongoing educational effort involving continuing generations of vulnerable youths remains a challenge.

Congratulations on keeping the war on tobacco in the spotlight.

Paul H. Steel, MD, FACS  
Atlantic City

1. Steel PH. Cigarette smoking in children. 1966. *J Med Soc NJ* 63: 555-557. Steel PH. Student ciga-

rette smoking habits. 1991. *NJ Med* 88:277-279.

Two of the authors reply: Our thanks for highlighting supplementary data sources on youth tobacco use in Atlantic County. Trends summarized in these articles are consistent with the national "Monitoring the Future" studies, which indicate a peak in youth cigarette smoking in 1976, a decline throughout the late 1970s and 1980s, and a sharp rise in youth smoking during the 1990s.<sup>1</sup> Unfortunately, such representative data has not existed statewide in New Jersey, highlighting the importance of the New Jersey Youth Tobacco Survey (NJYTS).

The NJYTS is the first measure of prevalence for all tobacco product usage among a statewide representative sample of middle and high school students. Data from the baseline NJYTS will be instrumental in monitoring the success of the NJ Comprehensive Tobacco Control Program over time. In addition, the data will allow NJ to make comparisons with other states that implement the YTS protocol under the CDC framework.<sup>2</sup>

Thirty-five years have passed since the initial survey of Atlantic County youth in 1965. We hope that the current commitment to tobacco control will have the sustained passion and enthusiasm demonstrated by Dr. Steel.

Cristine Delnevo, PhD, MPH,  
UMDNJ-School of Public Health.

Dawn Berney, MPA, New Jersey  
Department of Health and Senior Services.

1. Johnston LD et al. *National survey results on drug use from the Monitoring the Future study, 1975-1998: Volume I, Secondary school students.* (NIH Publication No. 99-4660). (Bethesda MD: National Institute on Drug Abuse, 1999.)

2. Centers for Disease Control and Prevention. *Youth Tobacco Survey Workshop—Look to the Future, September 15-17, 1999.* US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

## CYBER DRAWBACKS

What Dr. Richard Reece ("Physician Practice Support in Transition," July 2000) fails to appreciate is the fact that those of us in private medical practice are in the business of selling our analysis of problems and advice for their solution. I encourage my patients to educate themselves by surfing the Web. I also invite them to bring in printouts that they have collected so that we can have appropriate discussions. However, I charge fees for the time spent in consultation with me on such matters. If I were to communicate with my patients about their questions and problems via the Internet, I would be intruding on my personal and family time and committing economic suicide.

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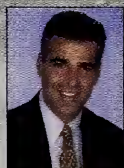
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# Seizing the Day in the New Century

Walter J. Kahn, MD

Over the course of our 234-year existence, the needs of MSNJ members have changed radically. To address these needs as well as a declining membership base, last year our Board of Trustees hired Ernst & Young to study our organizational structure. Under Dr. Fred Palace's leadership, a task force containing board and county representation worked closely with the consultants.

Ernst & Young conducted in-depth interviews of more than 140 individuals and sent surveys to our entire membership. In addition, it thoroughly reviewed the operations of five MSNJ county societies and interviewed nine other state societies. The results show that members perceive several deficiencies: poor communications at both the state and county levels, duplication of services, inefficient billing and accounting processes, and competition and distrust between state and county organizations.

A few years ago the county organization was our world, both medically and socially. Although the county's local presence still provides some value, the overall structure is considered archaic. Our world has changed and expanded. We now have hospital systems that cross county lines, the Internet, competing organizations, more demands on our time, and a new generation of members demanding value and efficiency.

Above all, the membership wants assistance in fighting managed care. Can this assistance—and other services—be provided when county capabilities range from full-time staffs and executives to empty offices with answering machines?

The task force has recommended establishing three to four regions in our state to consolidate services, while keeping the political structure of each county intact. It doesn't make sense to maintain two county offices a few miles apart

or for the county and state organizations to have incompatible computers. Regional offices can provide members added value, with a physician-service team to help with such issues as practice management and technology. If counties regionalize, their present employees will be guaranteed employment for at least three years.

Such changes are never easy. The board and county presidents openly discussed the study's recommendations at our October meeting. They will follow that with a larger one-day retreat to determine appropriate courses of action regarding regionalization and the study's other findings. We expect to vote on those actions at the November meeting.

MSNJ has already started work on communication issues, which will be crucial in moving forward with other changes. Members routinely receive blast faxes and letters. We've begun a series of hospital medical staff presentations on our many achievements to inform current members and attract new ones. *New Jersey Medicine* and our Web site, which are continually being improved, will carry timely news about important Board of Trustees actions.

Over the next year, many tough decisions must be made. We can decide whether to move forward with changes now while we're still strong or wait till we implode. That is really no choice at all.

Minutes of every Board of Trustees meeting are posted on the MSNJ Web site shortly after the meeting. Go to [www.msnj.org](http://www.msnj.org), press "Members Click Here," enter your user name and password, select "Resources" from the member menu, press "Go," and click on the "Board of Trustees Highlights" button. Send comments and feedback to [info@msnj.org](mailto:info@msnj.org).



# Raymond V. Gilmartin

*Chairman, President, and CEO, Merck & Co., Inc.  
Chairman, Healthcare Institute of New Jersey*



**T**he global pharmaceutical firm Merck & Co. and the Bill & Melinda Gates Foundation recently announced the Comprehensive HIV/AIDS Partnership, which will work with the government of Botswana in a pilot project to improve the care and treatment of HIV/AIDS in that country. Botswana has the highest rate of infection of HIV/AIDS in the world. Other organizations and pharmaceutical firms will also be a part of this extraordinary initiative.

The announcement of this project recalled the efforts of Merck to prevent and cure river blindness (onchocerciasis), several years ago. This disease, which affects millions in Africa and parts of South America, causes agonizing itching, disfigurement, and eventual complete blindness. Merck developed a drug, Mectizan, which prevents and treats river blindness with as little as one dose per year. The company provides the medication at no charge and worked with world health care organizations to develop the infrastructure to deliver the drug and provide treatment, all at its own cost. (The fascinating story of river blindness and Mectizan is told in a separate article in this issue.)

Impressed with these examples of corporate responsibility, *New Jersey Medicine* (represented by MSNJ Executive Director Vincent A. Maressa and Editor Paul J. Hirsch, MD) interviewed Raymond V. Gilmartin, chairman, president, and CEO of Merck & Co., Inc. in his office in Whitehouse Station NJ.

Mr. Gilmartin has led Merck since 1994. He is also chairman of the Healthcare Institute of New Jersey (HINJ) and past chairman of the

Pharmaceutical Research and Manufacturers of America. He is very much involved with health care delivery in New Jersey, as the immediate past chairman and trustee of the Valley Health System.

We found Mr. Gilmartin to be direct and forthright in his answers to our questions and not at all reluctant to provide opinions about some of the most difficult problems that face health care today.

**New Jersey Medicine:** We are particularly interested in the project that you recently announced to treat and prevent HIV/AIDS in Botswana. Please tell us more about it and what its goals are.

**Mr. Gilmartin:** We had been working on the possibility of a Botswana-type project for more than a year. Our goal was to have a pilot or model country in Africa in which we could demonstrate a comprehensive approach to the problem of HIV/AIDS. This program, with the cooperation of the government of Botswana and with the financial assistance of the Gates Foundation, can accomplish this goal. The Gates Foundation contribution of \$50 million over five years will help to provide the needed investment in health care infrastructure.

The problem was not simply the cost of pharmaceuticals. There were general principles that were arrived

**A successful partnership and a successful program can significantly improve the level and quality of HIV/AIDS care in Botswana.**

at with the World Health Organization (WHO). We would require broader and more comprehensive care for AIDS patients than just anti-retroviral drugs. It would, for example, include prevention, health care delivery systems capable of getting medications to the people, palliative care, and treatment of opportunistic infections.

Merck and four other pharmaceutical companies (Boehringer-Ingelheim, Bristol-Myers Squibb,

GlaxoWellcome, and Hoffmann-La Roche), worked with the WHO, the World Bank, and UNAIDS [the United Nations umbrella group that coordinates AIDS-related activities], to try to solve the problems of getting AIDS drugs to developing countries, especially in Africa. It was important to recognize that it really would take a partnership of all of those entities to accomplish this task.

Part of the significance of this alliance is that historically, the WHO has not been eager to work with the pharmaceutical industry. Its leadership is now committed to working together.

We are coming at the issue as a true partnership. The government of Botswana is forward thinking and has the political will to deal with this issue. They are the ones closest to the problem. We have no intention of coming in and dictating what should be done. We hope and expect to develop a model that can be replicated in other countries and that will be a sustainable solution to this tragic problem of HIV/AIDS.

Botswana has a population of approximately one and a half million people; about one-third of the population is infected with HIV. A successful partnership and a successful program can significantly improve the level and quality of care in Botswana. We



are very excited about the program and about the participation of the Gates Foundation.

Our experience and our ability to act as a catalyst to bring this about had its roots in the Mectizan project for river blindness. Although Merck was willing to give the drug away, it took about three years until the first dose was delivered, because of the complexities we are talking about: absence of a health care infrastructure, lack of means of delivery to people, and lack of political will and leadership. And this required only one tablet per year per person, no special storage requirements, and no requirements as to possible interactions with other medications. We learned a great deal from that project, working with the WHO, the World Bank, the Carter Center, and others. That gave us not only the confidence to undertake the Botswana AIDS project but the credibility with other organizations that we could actually accomplish this. We are quite excited about the prospects.

**NJM:** Merck has, as have many other companies, always emphasized an interest in “ethics” and has done more than just talk about it. You have, for example, provided the funding that made possible the Gulf Centre for Excellence in Ethics (GCEE) in the United Arab Emirates. The emphasis of the GCEE programs is to further ethical business practices in the region. Could you tell us about this? Do you have similar programs for biomedical ethics?

**Mr. Gilmartin:** We place a strong emphasis on business ethics. We make clear statements about what we hope to achieve at Merck, and we also care a lot about how we achieve those results. Did we treat people inside and outside the company with dignity and respect? Have we conducted ourselves in a manner consistent with the highest tenets of ethical behavior? We think

that this is a source of competitive advantage for us. It is a reason that we are able to inspire trust among physicians, regulators, and patients who use our products. Having the trust that results from ethical behavior is, we think, a key component of our success. Since we have been growing and expanding very rapidly, we have undertaken a conscious effort to make it clear, worldwide, just what Merck’s ethical standards are regarding the way we do business.

In some countries, where business practices may be different from the US, we are able to provide the example of many highly motivated Merck employees who attribute a great deal of their success to the ethics and standards that we have established. We try to convey to others, especially in developing countries, that just as we see ethics as a key to our own success, ethical behavior and ethical business practices are a key to their success as well. For Merck to participate successfully in those countries, we need an environment where there is rule of law and also ethical behavior and ethical business practices.

We have been very pleased by the very positive reaction to our programs on ethical behavior, including the GCEE. There is a lot of interest in similar programs elsewhere.

Although we do not have a formal program similar to the GCEE for biomedical ethics, much of what we do ties into our concern for ethics at every level.

**We place a strong emphasis on business ethics.**

Merck scientists, many of whom are MDs and PhDs, often tell me that they are with Merck because of our ethical standards, our standards for research and clinical studies, and our safety standards. Our ethical concerns certainly include the ways in which we present ourselves to physicians—how our field sales representa-

tives approach physicians. This also a very important part of our business conduct.

As with Mectizan and AIDS drugs, we feel a responsibility extending beyond the discovery of a drug. It extends to helping people obtain access to the drug, and that is why we are active in promoting Medicare reform and why we are involved in Botswana. We believe that it is important that the right populations use our drugs, in the right way, so that they deliver the health benefits that are promised.

**NJM:** Does Merck do its own clinical studies, or do other organizations do them for you?

**Mr. Gilmartin:** We do our own studies for the most part. This is a core competence that we have, and it is critical to our success, so we hold it pretty close. We do some contract work with other organizations for additional capacity when we have a heavy workload, but when we do, we monitor them very closely and carefully.

**NJM:** You have just begun your term as chairman of the Healthcare Institute of New Jersey (HINJ). What are your goals for that organization?

**Mr. Gilmartin:** Our primary goal is to continue the process of informing our legislators in the state and in Congress, as well as the people of New Jersey, just how significant the pharmaceutical industry is to the state. As Governor Christie Whitman has said on many occasions, New Jersey is indeed the medicine chest of the world. New Jersey companies discovered about 31% of drugs approved by the Food and Drug Administration (FDA) during the past five years, and collectively we spend about \$5 billion in research each year. The member companies of HINJ are spread throughout the state, with more than 100 facilities in

**We feel a responsibility extending beyond the discovery of a drug. It extends to helping people obtain access to the drug.**

16 counties, and employ more than 50,000 people.

We have all been expanding as well. I think that Merck is representative. We have new research facilities in Rahway, new manufacturing additions, and upgrades in technology. We are expanding employment, particularly in the research area.

I once heard a speaker comment that it is dangerous to be successful without understanding why you are successful. It would be easy to take the pharmaceutical industry for granted

and not understand why this industry has been successful. One reason is that we have a free market for pharmaceuticals in the US. We, as a nation, make significant investments in basic research, through the National Institutes of Health (NIH) and through academic research centers, which train scientists and also develop basic and fundamental knowledge. We also have intellectual property protection in this country. Patents are not a barrier to competition, but they certainly do stimulate innovation. And we have access to global markets.

In recent years the FDA has been particularly effective in approving drugs on a timely basis and is really the gold standard for the world. This enhances our credibility in the world market.

At the same time, we are a highly visible and sometimes controversial industry, because we play an essential role in people's health. There are legitimate concerns about drug costs and there are good answers. We in the industry face the challenge of getting our message across and effectively communicating the high level of competition within the industry.

There is still a lot to do, and we must continue to develop the relationships with legislators at the state and federal levels, so that our legislators will support



and protect the enabling conditions that have made this industry so innovative.

We are grateful for the excellent reception that we have and the excellent hearing that we have had from our state and federal legislators and from the governor's office and her staff. The Healthcare Institute has had discussions with the governor regarding the cost of pharmaceuticals and the best ways for the state to deal with this to ensure that there is access and appropriate utilization.

Historically, we have been well known as individual companies in the state. The formation of HINJ provides an opportunity for the industry to discuss our collective impact on New Jersey. We believe that HINJ has had success in its goal of presenting our message, but we still have more work to do.

**NJM:** NJ KidCare is a program that provides health coverage for uninsured children age 18 years and younger. We know that the Healthcare Institute has been an active supporter of that program and that Michele Guhl, New Jersey's Commissioner of Human Services, has praised your industry for the support that you provided. Please tell us about it.

**Mr. Gilmartin:** NJ KidCare (now part of NJ FamilyCare) was launched in 1998 to offer affordable quality health care for children who may qualify for health insurance at low cost or no cost, depending on family income.

In 1999 our members agreed to work together to help increase the enrollment in NJ KidCare, because we share its goal of increasing access to health care for all individuals. HINJ members supported these efforts with a financial commitment and also with hands-on involvement. When we learned that the application form was a barrier to enrollment for

many, employees from our member companies worked to rewrite and redesign a simplified form. We developed community partnerships to increase enrollment through school-based programs. HINJ also reached out to the New Jersey Nets and provided financial support for their involvement in encouraging enrollment. We are pleased with the chance to work with the administration on this important program for New Jersey.

**NJM:** Recently, the Maine legislature enacted a bill that would place price controls on prescription medication. How do you view that?

**Mr. Gilmartin:** The real issue to be addressed here is getting insurance coverage for people on Medicare. That is the population that is most affected by having to pay full retail prices for pharmaceuticals. The Maine program seeks to obtain discounts for people as a solution to the problem. We believe that the solution lies in obtaining access to insurance coverage for prescription drugs.

Merck has taken a leadership role in promoting prescription drug coverage as part of a comprehensive reform of Medicare. We have also gone one step further and called for insurance for prescription drugs as an interim step toward reform. Legislation passed by the House of Representatives, the Medicare Rx 2000

Act (introduced by Congressman Bill Thomas, R-CA), is the model that is closest to what we think is the appropriate way to go about doing this. There is similar legislation that is in the process of development by Senators John Breaux (D-LA) and William Frist (R-TN), based on the principle that people should have choice of health plans and insurance plans and that these plans should be

**New Jersey  
pharmaceutical  
companies  
collectively spend  
about \$5 billion in  
research each year.**

competing with each other to improve the quality of offerings for the beneficiaries.

This model of competition and choice already exists in the private sector and has helped to create the environment that has allowed the US pharmaceutical industry to be so successful at innovation. It is the reason that, over the past 10 years, our industry has discovered about half the world's drugs, and that percentage is likely to increase dramatically over the next 10 years. We are the only country in the world with a free market for pharmaceuticals, where competition determines the price just as it does in every other industry.

Price controls, whether at the federal or the state level, will be detrimental to innovation. The evidence for this exists in Europe, Japan, and Canada, where their industries have nowhere near the level of pharmaceutical innovation and research activity that we have in this country. To ensure that we will have needed research and that people have access to innovative drugs, it is crucial that we view this as an insurance problem and not as a problem of obtaining discounts for medications.

**NJM:** We would like to compliment you on your presentation to the AMA National Leadership Conference in March 1999. In that talk you covered a number of issues, including coverage for the uninsured. We are interested in your views on this and how you think that we can accomplish this coverage on a national basis.

**Mr. Gilmartin:** Merck is involved in the Healthcare Leadership Council, based in Washington DC. The council's mission is to advocate competition and choice as a means of solving health

**HINJ members work together to help increase the enrollment in NJ KidCare because we share its goal of increasing access to health care for all.**

care issues, including cost, quality, and access, in this country. We advocate the use of private-sector, as opposed to government, models as a way of delivering health care to people.

Therefore, our first principle in dealing with the uninsured is to decide how we extend our private-sector approach, to help give the uninsured the same access and choice of plans as others have. The

key first step is to do a careful diagnosis as to why people are uninsured. There are many uninsured populations, with different needs. Then we must tailor the solution to those particular needs.

In some cases, as we are attempting with prescription drug coverage in Medicare, we promote a private-sector approach, with competing health plans, and providing targeted subsidies to those at the lower income levels, so that it is more affordable. In other cases, it may mean fully deductible premiums for those who are self-employed or tax incentives for smaller businesses. We would try to tailor the solution to the specific problem. Also remember that many people are uninsured for only a short period of time. They may, for example, be between jobs and choose not to take advantage of interim programs that would provide them with insurance.

**NJM:** That seems to envision private coverage, with a subsidized mechanism for going into the private market. Do you believe, then, that the answer for the uninsured is to obtain coverage through the private sector, either through a direct-pay or on a subsidized basis, as opposed to putting uninsured into a government-run program?



**Mr. Gilmartin:** That is exactly what we recommend. We have enough experience with other countries to know what government-run systems are like. The private sector is particularly effective at allocating resources according to people's needs and choices. In the private sector, people choose to have health care coverage and to spend money on health care coverage. It is seen as a valuable good, rather than as a problem.

We are encountering this now with prescription drugs. Because of our high level of innovation as an industry, spending for drugs is increasing by approximately 16% a year. Only a small portion of that, about 3% of the 16%, is due to inflation and price increases. In Merck's case, price increases have been less than inflation, so that real prices are going down. The real drivers of increased expenditures for medications are increased use and the introduction of new drugs.

In our society we view that as positive. People are getting better health care, and they have access to innovative drugs. In a government system, as in Europe, this would be viewed as a problem and a cost, not offering value; therefore, they ration. That is a totally unacceptable solution for this country.

**NJM:** A number of drug companies, including Merck, are participating in a program to make medicines available to needy senior citizens at different levels of reimbursement or at no cost, depending on circumstances. Most people are unaware of this. Could you elaborate on it?

**Mr. Gilmartin:** There is such a program. Physicians must enroll their patients and must take the appropriate steps to help patients gain access. If they are truly in need, they will obtain access to drugs. That is the idea of it: no one should be denied access to the drugs that they

need. However, this addresses only a small part of the population.

**NJM:** You are the immediate past chairman of the Board of Trustees of the Valley Health System in Ridgewood, which has been quite successful in meeting the challenges of the changing environment of health care delivery. What do you attribute this success to?

**Mr. Gilmartin:** Under the leadership of Michael Azzera, our president, Valley Health System determined a number of years ago that the best way to deal with the cost of health care was to continue to improve the quality of how it is delivered. This is very much the way that private industry would look at it: the way to control cost is to improve quality. This philosophy pervades Valley Hospital, from levels of patient satisfaction to how the medical staff views what it does on a day-to-day basis in the nature of the care that it is delivering.

Close cooperation among the nursing staff, the administration, and the physicians has been critical to Valley's ability to execute its ideas about improving the quality of care and patient well-being. Valley Hospital is very patient-focused and it has integrated its services with this in mind.

**We are the only  
country in the world  
with a free market  
for pharmaceuticals,  
where competition  
determines the  
price, just as it does  
in every other  
industry.**

In the broader definition of quality, the hospital has continued to increase and improve its level of sophistication and innovation in providing medical services to the community.

The hospital has also maintained a very strong community presence and involvement. Its community relationships and its role as a community hospital have been a real source of strength.

**NJM:** Thank you, Mr. Gilmartin. We look forward to talking with you again.

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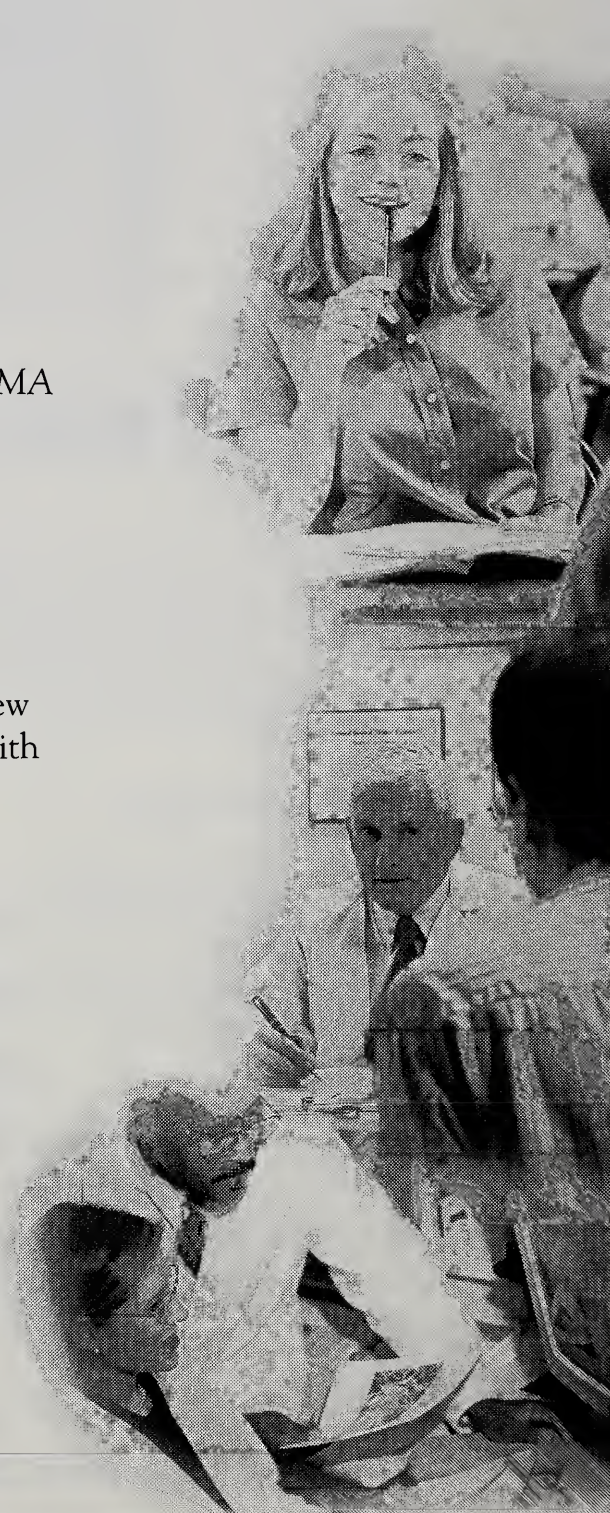
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# Merck: Committed to Access to Medicines for Patients Throughout the World

Raymond V. Gilmartin

At Merck, we are proud of our commitment to breakthrough research and what it means to global health. Patients have renewed hope—and greater potential—for longer, healthier, more productive lives. Physicians have new treatment options with proven health outcomes.

But as proud as we are of our breakthrough research, we know our work is not done unless people around the world have access to our medicines.

This belief is a direct outgrowth of Merck's core values, which were eloquently articulated by George W. Merck, the company's president from 1925 to 1950. In a 1950 address at the Medical College of Virginia, he said, "We cannot rest until the way has been found with our help to bring our finest achievement to everyone."

Success at Merck is measured not only by how well we execute our core commitment to research and development, but also by how well we help ensure that patients throughout the world have access to the medicines they need.

## CORE VALUES CLINCHED DECISION TO DONATE MECTIZAN

It was these core values expressed by George W. Merck that led Merck to decide in 1987 to donate Mectizan (ivermectin) for the treatment of river blindness (onchocerciasis) to those who need it for as long as needed.

The transmission cycle of river blindness begins with the bite of a common blackfly carrying the microscopic worm *Onchocerca volvulus*. Mectizan paralyzes the microscopic worms, thereby stopping their constant movement in the body and alleviating the symptoms of the disease and preventing blindness. To be fully effective, people must take Mectizan once a year for 12 years—the average life cycle of the worms. River blindness primarily affects people in sub-Saharan Africa, parts of Latin America, and Yemen. According to the World Health Organization, about 18 million people are living with river blindness, while approximately 120 million people remain at risk of contracting the disease.

Considering that Mectizan is the only safe and effective treatment for

river blindness, Merck felt an especially strong ethical obligation to make it available to the people who needed it but also were the least able to pay for it.

Today, the Merck Mectizan Donation Program is a unique multisectoral coalition involving Merck, the World Health Organization, the World Bank, UNICEF, the Carter Center, the United Nations Development Organization, the Food and Agriculture Organization, the Mectizan Expert Committee, dozens of national ministries of health, representatives of the international donor community, more than 30 nongovernmental developmental organizations, and local community health workers.

This public/private-sector partnership has helped the Merck Mectizan Donation Program produce great success over the past 13 years—reaching an estimated 25 million people annually.

Gro Harlem Brundtland, director-general for the World Health Organization, said last year: "Thanks to a landmark example of public/private-sector collaboration, the transmission of the disease [river



blindness] is on the verge of elimination in West Africa. An estimated 12 million children who would have otherwise lived with the risk of being blinded by onchocerciasis have grown up to be independent and productive adults."

In 1998, Merck expanded the donation program to use Mectizan for the prevention of lymphatic filariasis (commonly known as elephantiasis) in African countries where the disease coexists with river blindness. The World Health Organization estimates 300 million Africans are at risk of lymphatic filariasis.

## COLLABORATION FURTHERS POSITIVE IMPACT

Merck is especially proud that the Merck Mectizan Donation Program has served as a model for other pharmaceutical companies. And Merck also continues to apply lessons learned from this extraordinary program.

In July, Merck, along with the Bill & Melinda Gates Foundation and the Republic of Botswana, announced the establishment of the Botswana Comprehensive HIV/AIDS Partnership. The partnership will endeavor to significantly advance HIV/AIDS prevention, health care access, patient management, and treatment of HIV in Botswana, a country where an estimated 29% of the adult population is HIV-positive. The Gates Foundation will dedicate \$50 mil-



*In October 1995, a seven-foot sculpture named The Gift of Sight was unveiled at Merck's corporate headquarters in Whitehouse Station. It shows a young boy leading a blind man along a path in an African village—a once common scene that is disappearing as a result of Merck's decision to donate Mectizan wherever needed for as long as needed to control river blindness. The same statue also stands at the Carter Center in Atlanta and at the World Bank in Washington DC.*

lion over five years to help Botswana fundamentally strengthen its primary health care system. Merck and the Merck Company Foundation will match the Gates Foundation funding through the development and management of the program and the contribution of antiretroviral medicines.

Although in many ways river blindness is a much simpler disease to combat than HIV/AIDS, the Merck Mectizan Donation Program helped us gain credibility with important organizations—such as the World Bank and the World

Health Organization—and gave us first-hand experience and confidence in dealing with complexities like the absence of a health care infrastructure and a delivery means to people.

Merck believes that targeted and comprehensive interventions will lead to long-term health care solutions to the challenge of the HIV/AIDS epidemic in developing countries. By focusing intense efforts on Botswana, we hope to show what can be achieved with comprehensive interventions across the entire spectrum of care, from voluntary testing and counseling and education to the provision of increased access to medicines and appropriate monitoring of treatment. Since our announcement of this program, other pharmaceutical companies have joined this partnership.

The Botswana Comprehensive HIV/AIDS Partnership will be conducted with the participation of other national governments; the Harvard AIDS Institute and other academic centers; global health and development agencies, such as the Joint United Nations Programme on HIV/AIDS (UNAIDS); non-governmental organizations; HIV community organizations; and people living with HIV.

## **PRESCRIPTION DRUG COVERAGE IS KEY TO PROVIDING WIDER ACCESS**

On the domestic front, we realize that, despite the enormous wealth of the US, there are people who also can't afford our medicines. And we believe all Americans should have access to the medicines they need. This is possible through extending quality health care coverage and encouraging the appropriate use of medicines for those who have coverage. We believe that the best way to provide health coverage is through private health coverage that allows competitive forces to deliver lower costs, improved choice, and a higher quality of care to patients and consumers.

For the population of those over 65 and disabled, Merck is taking a leadership role in advocating the modernization of the Medicare program to provide all beneficiaries with access to quality, affordable outpatient prescription drug coverage. The Federal Employees Health Benefits Program (FEHBP) provides an excellent working model for the type of Medicare program that would provide prescription drug coverage. That program incorporates the principles of quality and competition, along with streamlined administration and regulation. Because the modernization of Medicare may take time, Merck is actively promoting federal legislation that would provide all seniors with access to affordable pharmaceutical insurance coverage.

Merck also ensures its products are available to poor Americans

through discounts to government programs such as Medicaid, state programs for low-income seniors, the AIDS Drug Assistance Program and the Center for Disease Control, as well as through Merck's Patient Assistance Program.

The company's Patient Assistance Program provides free medicine for those who are experiencing short-term financial difficulties. The patient must have exhausted all options for prescription benefits and coverage. Patients must also reside in the US and have a US-based physician. Applications, which must be completed by both the prescriber and the patient, are reviewed on a case-by-case basis.

Once eligibility is verified, up to a three-month supply of the prescribed medication is sent directly to the prescriber's office for distribution to the patient. Most Merck products are available through the program.

### **MERCK-MEDCO TAKES LEAD DEVELOPING PRESCRIPTION DRUG-DISCOUNT PROGRAMS**

For people who have no or limited prescription drug coverage,

**About 18 million people are living with river blindness, while approximately 120 million people remain at risk of contracting the disease.**

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Anyone interested in the program can enroll by calling (877) 73-ENROL [(877) 733-6765], or through the Internet at [www.yourxplan.com](http://www.yourxplan.com). When members enroll, they receive a welcome kit that includes a membership identification card and complete instructions on how to use the program.

Merck-Medco also has been involved in creating other discount programs, including Washington state's recently announced program to provide seniors there with discounts of up to 49% on mail-order prescription drug purchases.

At Merck, we are serious about our mission to bring our finest achievements—our innovative medicines, research, and health care services—to everyone. We are committed not only to searching for cures but also to helping expand access to the fruits of our scientific discoveries. ■

*Raymond V. Gilmartin is president, chairman, and CEO of Merck & Co., Inc., headquartered in Whitehouse Station.*



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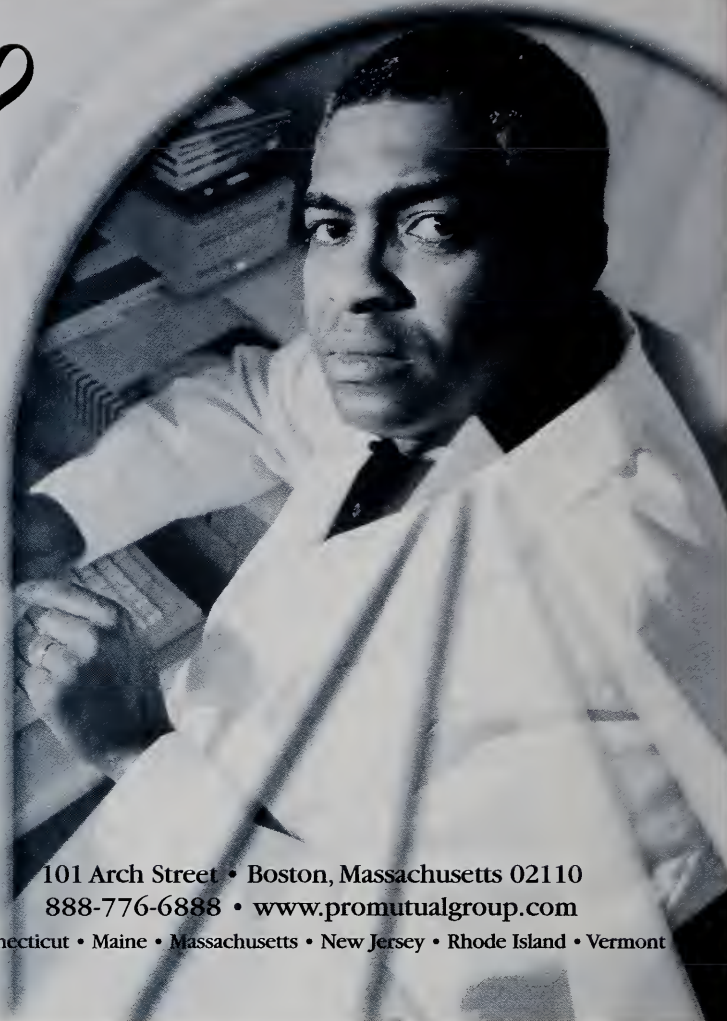
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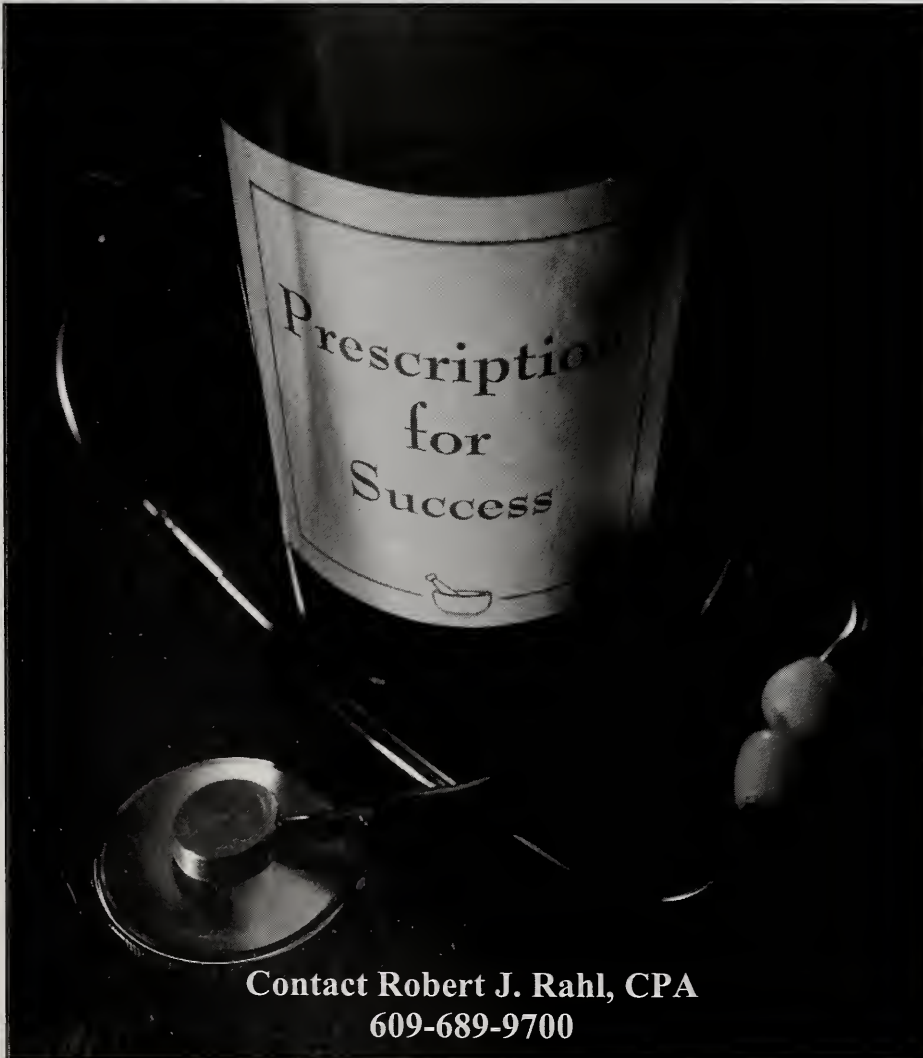
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# Patients Not Profiting From For-Profit Care

*Assemblywoman Loretta Weinberg*

**T**he turn of the century has passed, and there is plenty to be excited about. Our country has experienced unprecedented growth, and technology has taken us to places never before imagined. Perhaps most important, our discoveries and advances in science and medicine have provided us with new and energized hopes of healthier, better, and, ultimately, longer lives. This should be a time of euphoria for almost every American.

This special time, however, is being overshadowed by a dark cloud. As we have led the way in all these advances, with our state and country the objects of envy around the world, we have failed to find a way to guarantee affordable and quality health care to every single New Jerseyan and every last American. Without affordable health care available, we have accepted the burden of caring for the uninsured to maintain a safety net of care for every citizen. Public hospitals are the beacon of public welfare

and public charity. They have faced the challenge of caring for the sick while being able to pay the bills.



*Assemblywoman Loretta Weinberg*

That is why the latest trend is troublesome, especially in New Jersey. Our most precious resource—our health care—is slowly being turned from a public not-for-profit endeavor into a for-profit business. Advocates of providing health care in a private for-profit manner say there is much to hope for in terms of increased levels of care when privatization occurs. However, it is a trend that has

sometimes proved to be a mistake.

When the state's Division of Motor Vehicles was turned over to private operators, there were hopes for "service with a smile." Then the state's new enhanced auto inspection system was handed to the private sector with hopes of cleaner air and faster service. The results? Long lines, frozen computers, undue stress, and the poorest customer service possible. The situation with the DMV is an example of how



privatization does not always work for the delivery of services necessary to the public. The DMV, however, does not operate in a life-or-death situation for millions of people. The most that happens is you leave in a mood less than ideal. In our hospitals, however, we are dealing with an issue far more serious—the health and well-being of our people, many of them the more vulnerable among us.

When health care is provided in a private for-profit setting, we must ask the following question: how will the profit be generated? Certainly, the only way to turn a profit on Medicaid patients is to cut staff and services. The bottom line—they cut costs!

We have seen this type of cost cutting time and time again in hospitals and other health care facilities throughout New Jersey and across our nation. There have been reports involving privatized hospitals citing excessive bed sores; a lack of nutrition, exercise, activity, and stimulation; and a more generalized lack of care from staff at for-profit facilities. Sometimes the situations have been far more serious, as it has been suspected that patients have died in several facilities as a result of neglectful care.

All of this is not to say that our medical professionals are incompetent. In fact, the truth is quite the opposite. The problem is exacerbated when staff is terminated or working hours are reduced. The remaining staff is often overburdened by the number of patients for whom they must care and the number of hours they must work. The result is fatigue, burnout, exhaustion, and the inability to work to their

fullest potential. Our patients and health care professionals clearly deserve better than that.

That is why I am proud to be the first cosponsor of legislation in the state assembly that would prohibit health care facilities from requiring that hourly employees work overtime. The bill as originally passed would have allowed employees to volunteer for overtime but ensured that they would not be dismissed or penalized for not working extra hours. Although I disagree with Gov. Whitman's conditional veto of the portion of this legislation that allows for voluntary overtime, I was encouraged by her overall support for the initial goals of the legislation. This shows that there is indeed support for eliminating mandatory overtime.

This legislation will protect our health care professionals from fatigue and burnout and allow them to perform to their fullest potential. Naturally, the more we care for our doctors, nurses, and other health care professionals, the more care they will provide for their patients.

We must begin to find a way to create better environments for our patients and caregivers. Perhaps most important, we must do all we can to keep our public health institutions just that—public. To do otherwise is dangerous, unfair, and wrong! It is our responsibility to do all we can to protect our patients and health care professionals in every way possible. We must aim for nothing less.

*Loretta Weinberg is the deputy minority leader of the New Jersey General Assembly. She represents the residents of the 37th legislative district, comprising nine municipalities located in eastern Bergen County, and serves on the Assembly Health Committee.*

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# World AIDS Day: Men Make a Difference

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THIS YEAR, THE THEME FOR WORLD AIDS DAY, HELD ON DECEMBER 1, IS "MEN MAKE A DIFFERENCE." AS WE APPROACH WORLD AIDS DAY, IT IS TIME TO REFLECT ON OUR ACHIEVEMENTS, RECOGNIZE THE CHALLENGES AHEAD, UNDERSTAND THE IMPACT THAT MEN HAVE, AND APPRECIATE THE UNIQUE ROLE THAT PHYSICIANS PLAY IN PREVENTION AND TREATMENT.

*Sindy M. Paul, MD, MPH, and Gloria M. Rodriguez, DSW*

**T**he role of men and the difference they make in the HIV epidemic is emphasized in changing trends in the epidemic in New Jersey. Heterosexual transmission is playing an ever-increasing role. The proportion of women among both the cumulative AIDS cases and HIV cases is increasing. In 1990, women accounted for 23% of the cumulative AIDS cases in New Jersey. By April 2000, they accounted for 28% of the cumulative AIDS cases; from March 1999 through March 2000, women accounted for 34% of the reported AIDS cases. Women

also account for 40% of the reported HIV cases in New Jersey. This trend is particularly prominent among the 13-to-25-year-old age range. In this age range, men account for 61% of the cumulative AIDS cases. However, women account for 51% of the HIV cases, indicating increasing transmission to women.

The role of men in a comprehensive prevention strategy is extremely important. Men make a difference in sexual transmission of HIV because they actively participate in safer sex interventions such as condom use. Although a female con-

dom has been developed, it is difficult to use and hard to obtain. An effective female-controlled microbicide has yet to be developed. Even a previously recommended microbicide, nonoxynol-9 (N-9) has recently been shown to be ineffective against HIV transmission and poses the possibility of risk without benefit. Therefore, prevention of HIV transmission is a shared responsibility between men and women.

Many challenges persist in prevention. With the publicity surrounding the effectiveness of highly active antiretroviral therapy (HAART) and Magic Johnson's



pronouncement that he is "cured," consistent action on prevention messages has declined. New cases of HIV and AIDS are reported to the New Jersey Department of Health and Senior Services (DHSS) daily. In 1999, 1,465 new HIV cases and 1,970 new AIDS cases were reported.

Advances in medical management of HIV disease have improved the quality of life and life span of those who become infected. New classes of antiretroviral agents such as protease inhibitors introduced in the past four years have given clinicians more therapeutic options and allowed them to prescribe combination therapy. With combination therapy known as HAART, people were able to resume more normal lives and return to work. In New Jersey, through our Health Insurance Continuation Program, we saw an increase in persons with HIV disease returning to work from 1.2% in 1995 to 10.9% in 1999. The mortality rate associated with HIV disease decreased from 29.1 per 100,000 population in 1993 to 9.4 per 100,000 population in 1998.

As beneficial as HAART has been, there still is no cure. Many patients do well, then develop resistance to antiretroviral agents. Some patients require salvage therapy with as many as nine antiretroviral agents to minimize their viral load and maximize their CD4 count. Will new pharmaceutical agents such as fusion inhibitors be available soon enough for these patients? Can the pharmaceutical industry stay ahead of the virus? The NJDHSS has had a sentinel surveillance system for resistant strains of HIV since 1998. This system has detected resistance to protease inhibitors and other antiretroviral agents in treatment-naïve persons with newly diagnosed HIV infection. Will person-to-person transmission of resistant strains of HIV be a new trend in the epidemic?

The development of an effective vaccine remains a challenge. Vaccine clinical trials are under way in a number of countries. These trials have yet to demonstrate the safety and effectiveness of vaccines. Until a vaccine is available, prevention plays a key role in curbing the epidemic.

Physicians play an extremely important role in the HIV epidemic. They have a one-on-one rapport with their patients that can be a powerful prevention tool. Physicians can help HIV-negative patients remain negative and help HIV-infected persons remain healthy. A challenge for providers is to educate their patients about prevention while providing state-of-the-art treatment in an era in which both the clinical recommendations and the susceptibility pattern of the virus are rapidly changing.

*Sindy M. Paul is medical director and Gloria M. Rodriguez is assistant commissioner, Division of AIDS Prevention and Control, New Jersey Department of Health and Senior Services, Trenton.*

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# Pride of the Nation Tomorrow

## Where UMDNJ is Headed

THE FOLLOWING SPEECH WAS DELIVERED BY STUART D. COOK, MD, PRESIDENT OF THE UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY, DURING THE ANNUAL UNIVERSITY DAY EVENT IN SEPTEMBER.

It is a pleasure to provide the annual overview on the University of Medicine and Dentistry of New Jersey—to update you about what has been happening in our eight schools and review the progress we have made in achieving our five strategic goals.

I'm here to tell you that we're doing well and getting better every day. This is not just the optimistic view of a university president, because this year we have outside validation to back up my assessment. We have a report by reviewers from the prestigious Commission on Higher Education of the Middle States Association of Colleges and Schools.

The review team has given us very high marks, based on their assessment of a report prepared by a steering committee representing all our schools and health care units. I'd like to quote from the memo by the reviewers:

The university is a prominent academic health center coping well with the multifaceted changes in

resources, workforce, technology, and health care delivery. It is clear from the report that UMDNJ is aggressively pursuing institutional excellence through deliberate growth, strategic planning, strengthened internal and external communication, enhanced collaboration, and continuous quality improvement.

The team also commended the university for ensuring its institutional integrity, first by recognizing the pressures of a rapidly changing academic and health care environment, and second by actively responding to the challenges by developing and implementing a five-year strategic plan.

Last year when I unveiled the plan, I said that our challenge in this environment was to have a vision of ourselves as a successful health sciences university—an institution capable of bold decision-making when circumstances require immediate and decisive action. We now have that vision and are well on the way to achieving our goals.

At this time I would like to review the strategic intent and five goals.

Our strategic intent, "The pride of New Jersey today, the pride of the nation tomorrow," states our commitment to moving UMDNJ into the elite tier of academic institutions nationally recognized for their uniformly high caliber of scientific inquiry, innovative teaching methods, and clinical expertise.

In March 1999, we established five goals that were adopted by the university's Board of Trustees. They are:

- To double research revenues.
- To improve educational outcomes.
- To enhance patient care and patient satisfaction.
- To improve our efforts in community service and diversity.
- To build UMDNJ's reputation both statewide and nationally.

Based on observations of the Middle States' group and positive reports from several other accrediting bodies during the past year, our strategic goals are right on target.



Let's take a closer look at our accomplishments over the past year.

The goal to double research funding by 2003 is on track thanks to the efforts of our deans and faculty. Let me present a few examples:

- In academic year 2000, federal grant funding increased by an impressive 16%.
- We now have four university professors who are recognized as world-class researchers by their peers.
- We established four new endowed professorships—one in multiple sclerosis, two in child health, and one in cancer.

The construction of the International Center for Public Health in Newark is well under way. This project will bring together 250 scientists from the Public Health Research Institute and UMDNJ to form a world-class infectious disease research institute.

- The Board of Trustees approved a \$356 million university-wide capital construction plan. Within the next few months, we will break ground for exciting projects on the Newark, Piscataway, and Stratford campuses.
- We increased stipends for students enrolled in the Graduate School of Biomedical Sciences and expanded financial support for postdoctoral fellows.

Before I present our accomplishments related to educational excellence, I again quote from the Middle States' report:

We see truly remarkable accomplishments as a result of the university's high-quality education programs. Impressive student outcomes are

## **We now have that vision and are well on the way to achieving our goals.**

reflected in retention and graduation data, excellent performance on regional and national examinations, and recruitment and placement of students in graduate medical education.

The Middle States' review team also commended the university for its ongoing efforts to reshape the scope and size of its curriculum and for making changes that address current and future workforce requirements and changing health care practices.

The university's actions to support the educational excellence goal are highlighted today by the 12 faculty members who have become the first members of our Master Educators Guild. When I announced the creation of this program during my inaugural speech, I shared with you the results of a National Science Foundation survey of leading scientists who were asked what they felt was the most important factor in their education. The answer was almost uniformly the opportunity to work closely with a great and inspiring teacher.

The master-educator designation is the only award in which the selec-

tion process includes formal input from students, faculty peers, and administrators. The faculty selected exhibit the highest standards of educational excellence and have a true gift for teaching. In addition, they will have a unique role within the university. They will serve as a resource for evaluating curriculum, be provided funds to carry out educational research, become mentors to junior faculty to make them more effective teachers, and serve as a crucible for testing innovative educational concepts. They will be the university's guides to achieving educational excellence.

Finally, to support academic excellence during this academic year, we are undertaking a major initiative to increase funding for our university libraries, which provide the critical resources necessary for scholarly endeavors.

Now I turn to our activities in the clinical care arena. The university and its affiliated hospitals continue to provide the highest-quality care to the citizens of New Jersey. In fact, there is now growing evidence that the best patient care emanates from hospitals that are truly major academic health centers. This opinion is supported by a study published in the September 13 issue of the *Journal of the American Medical Association*, which shows that Medicare patients admitted to major teaching hospitals for treatment following a heart attack received better care, based on four indicators, and a lower mortality rate, than patients admitted to minor teaching or nonteaching hospitals.

The care we give is provided not only to those covered by private

insurance but also to the less fortunate members of our society who have no insurance at all and have no place else to turn. For example, University Hospital is the largest provider of charity care in the state of New Jersey. The Chandler Health Care Center in New Brunswick also provides health care to a large portion of the un- and underinsured in Central Jersey.

But in the current managed care environment, it is not enough to provide high-quality care to all our citizens. We must also remain financially solvent. In this regard, I note that the Middle States report cites the university for its ongoing initiatives to enhance marketplace competitiveness. I would like to cite just a few examples of this:

- A prototype for the centers of excellence concept has been approved by the deans of our medical and dental schools and submitted to the Board of Trustees.
- University Behavioral HealthCare generated \$5.2 million more in revenues than expenses last year while providing mental health access to more than 500,000 citizens in New Jersey.
- University Health Plans, the university's managed care company, has had its most successful year since it was established in 1994 and is a major insurer of Medicaid patients throughout the state.
- University Hospital, which faced a projected deficit of \$29 million for FY2000, closed the year with a deficit that is anticipated to be only \$8 million.

Our fourth goal defines our commitment to diversity and community service. Diversity has always been a major focus of UMDNJ, and over the years, we have received many national accolades for our success in building and maintaining a diverse student body that attempts to reflect the population composition of our state. In this academic year, to attract more outstanding disadvantaged students to our university, we are increasing scholarship support by \$500,000, which represents a 20% increase over our present scholarship funding.

Some of our other efforts on behalf of service to the community include:

- Serving as institutional chair of the newly created Governor's Council on Autism, whose purpose is to oversee and fund research initiatives related to this devastating childhood disorder.
- The creation of the Black Infant Mortality Task Force whose purpose is to draw on our faculty to help find answers to this serious public health problem.
- The hosting of three health care summits that addressed racial and

ethnic disparities in health care delivery.

Our fifth goal states our commitment to enhancing the university's image. We have evidence that this is happening at the statewide level. Based on the results of the UMDNJ/Eagleton poll we conducted last spring to measure public opinion of UMDNJ, I am pleased to report that our name recognition keeps growing.

We initiated a national public relations effort with the publication of Research 2000, which is sent to 12,000 scientists, academic leaders, and pharmaceutical company executives throughout the US, and the retention of Hill and Knowlton, one of the top public relations firms in the country.

We have also adopted a new university logo. It symbolizes the rededication of the university to excellence, and it expresses the essence of our very complex mission with three simple icons: a book connoting the importance of education, a flask symbolizing our world-class research, and a caduceus representing the commitment of our faculty and students to the healing arts.

We have our work cut out for us during this academic year if we want to maintain our commitment to excellence in the fast-paced, highly competitive environment in which we operate. It's clear to me that our strategic intent and five goals provide a clear road for building the institutional excellence that has been UMDNJ's hallmark since its inception 30 years ago. 

**The university and  
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hospitals continue  
to provide the  
highest-quality care  
to the citizens  
of New Jersey.**



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# Medicine and Mediation: Healing the Conflicts that Divide Us

Leonard J. Marcus, PhD, and Barry C. Dorn, MD

**A**lthough it is a coincidence that the words medicine and mediation share their first four letters, they have other things in common. They are both methods for healing. They are both fields of practice in which an outside party seeks to enhance the curative process: curing the body, curing relationships. And they are both interventions that occur at a point in time: the earlier the better.

With the health care system reeling in conflict in recent years, these two fields of practice are engaged in a fruitful process of getting to know one another. Medicine has taught the field of dispute resolution a great deal about what occurs in a field of high-stakes conflict and complex decision-making. In the words of *Getting to Yes* author Bill Ury, "A hospital makes US-Soviet relations look like a piece of cake."<sup>1</sup>

Likewise, mediation has taught medicine a good deal about the benefits and techniques of building interest-based negotiation techniques into everyday medical practice. As physicians, we must integrate a great deal of information, perspective, and experience into every decision. If the people who contribute to that decision-making process are in conflict, the very process of making high-quality,

cost-conscious, and time-sensitive choices is compromised. Conflict can be destructive or constructive. It is destructive if people avoid it, run from it, or cover it up. It can be constructive if people deal with it, manage it, resolve it, and most important, learn from it so it doesn't recur.

What is mediation and how does it pertain to what we do as physicians?

## MEDIATION DEFINED

Mediation is the use of a neutral third party who assists people in conflict to negotiate a resolution of their dispute. The mediator is not a judge and does not determine who is right or who is wrong or how the dispute should be resolved. Rather, the mediator helps the parties exchange their different points of view, develop a wider understanding of the problem and potential solutions, and develop a set of workable options or alternatives for resolving the issues, and then assists them in generating a mutually acceptable agreement.

Similar to patients who call their doctor only after they have experienced symptoms, disputants generally call on a mediator only when they are at an impasse. The motive for bringing in a neutral third party usually stems from the perceived costs of not resolving or of escalating

the dispute. If the stakes are high, both sides can recognize the relative benefits of resolution.

Mediation itself is a voluntary and confidential process. The decision to engage with a mediator is one that must be accepted by both sides. Similarly, the details of settlement itself and its acceptance are at the discretion of the parties. This is one of the strengths of mediation: everyone knows they are participating because they want to make the process a success. By contrast, litigation and binding arbitration are not voluntary: it is the judge, jury, or arbitrator who determines the outcome of the dispute.

## MEDIATION AND MEDICINE

The following sections discuss practical applications of mediation that are contributing to the resolution of important issues affecting medicine and health care.

**Consumer Disputes.** Both the Massachusetts Board of Registration in Medicine and Harvard Pilgrim Health Care have adopted mediation programs that give patients and physicians the opportunity to meet with a mediator to resolve their differences. The board's voluntary mediation program addresses complaints filed by patients after an adverse outcome, error, or miscom-



munication. What we have found is that after such a problem, patients or family members have three primary interests: to know exactly what occurred and why; to receive an acknowledgment or apology from the caregiver; and to know that whatever happened to them will not happen to another patient. In other words, patients are motivated to encourage corrective actions to enhance future patient safety.

The managed care mediation project addresses benefits disputes. Besides its successes in constructively resolving disputes, the project has also been a valuable tool for the organization to learn how it can improve services and operations.

**Professional Disputes.** The consolidation of medical practices, growth or change of those practices, or daily economic and professional pressures facing doctors can result in conflict. These conflicts can be very costly to the practices and the physicians involved, not only in time and money but also in lost market opportunities. Mediators are used to help the parties sit down with one another, constructively identify their differences, consider options that would be mutually acceptable, and then translate those discussions into meaningful and constructive new agreements. Especially in circumstances in which the conflict has taken on a strong emotional dimension for those involved, having a mediator to facilitate the discussion is a wise use of time and resources.

**Organizational Disputes.** Hospital mergers, provider-payor negotia-

tions, and large system changes have also prompted medical leaders to call on the services of mediators. When two hospitals combine, the decision usually results from meetings among a select group of institutional leaders. The real work of consolidation occurs at the front line, where people must balance different organizational cultures, procedures, and reputations. The job is all the more difficult if there are positions to be cut or procedures to be changed. Mediators can be helpful in structuring the change process, especially when friction among work groups is present. The negotiations between payors and providers can also be helped by the use of mediation, especially when talks that had previously taken place at a time of "plenty" are now taking place at a time of constrained resources.

**Policy Disputes.** As the health system experiences dramatic changes in its organization and reimbursement, the interface between the public and private domains can be beleaguered by disputes. Mediators have been used to facilitate conversations between these sectors as well as among private organizations as they consider how to address health policy issues, especially when there are differences among membership about how best to address specific issues.

## BUILDING THE BRIDGE

In part, good conflict resolution is fostered by constructive, interest-based negotiation. Many doctors find that they lack training or expertise in these methods and are

attending courses and studying the literature to enhance their skills. They find that models for multidimensional problem solving can be productively integrated in how they interact with patients and colleagues.

Some doctors go the next step: they actually train to become mediators. These medical mediators are able to go into a conflict and immediately understand the issues, context, and potential solutions and are thereby able to guide disputing physicians efficiently and effectively toward a set of feasible solutions.

Most important, this new combined field is creating new options for resolving disputes. Conflict is costly: there are lost opportunities, wasted time, and even worse, compromises in patient care. For these reasons alone, the linkage of mediation and medicine makes sense, because healing the body and healing relationships are often so closely intertwined.

Leonard J. Marcus is director of the program for health care negotiation and conflict resolution at the Harvard School of Public Health. Barry C. Dorn is CEO of Health Care Negotiation Associates. They are the authors of *Renegotiating Health Care: Resolving Conflict to Build Collaboration* (San Francisco: Jossey-Bass Publishers).

## REFERENCE

I. Fisher R et al., eds. *Getting to Yes: Negotiating Agreements Without Giving In* (New York: Penguin Publishers, 1991).

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# Influenza:

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## Prevention and Treatment

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INFLUENZA VIRUSES ARE RESPONSIBLE FOR MORE THAN 20,000 DEATHS AND MORE THAN 110,000 HOSPITALIZATIONS ANNUALLY IN THE US. FOR THE 2000-2001 FLU SEASON, BECAUSE A DELAY IN INFLUENZA VACCINE AVAILABILITY IS LIKELY, THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES HAS MODIFIED ITS INFLUENZA VACCINATION RECOMMENDATIONS.

*Jamie L. Reedy, MD, MPH; Cindy M. Paul, MD, MPH; Martin T. Zanna, MD, MPH*

Influenza, commonly called the flu, is a serious disease caused by the influenza viruses. These common pathogens cause disease in all age groups: the rate of infection is highest among children, but the mortality rate is highest among elderly and high-risk persons. Influenza viruses cause epidemics nearly every year during the winter and are responsible for more than 20,000 deaths and more than 110,000 hospitalizations annually in the US.<sup>1,2</sup> Influenza has a high attack rate; in family practice offices, as many as 11% of patient visits are for influenzalike illness during the peak of an influenza epidemic.<sup>3</sup>

Vaccinating persons at high risk for complications each year is the most effective way to reduce the impact of influenza. In addition, neuraminidase-inhibitor antiviral medications have been approved by the Food and Drug Administration (FDA) for chemoprophylaxis or treatment of influenza as an adjunct to the vaccine.<sup>1</sup> With a concerted effort from the public and private sector, we can increase the influenza immunization rate among New Jersey residents from the 1999 level of 65%.<sup>4</sup>

This year, the recommendations of the Advisory Committee on Immunization Practices (ACIP) include the following five principal changes:

- Lowering the age for universal vaccination from 65 years of age to 50 years of age.
- Delaying large vaccination campaigns until early to mid-November to minimize cancellation of vaccine campaigns and wastage of vaccine doses resulting from delays in vaccine delivery.
- Indicating that the composition of the 2000-2001 trivalent vaccine strains are A/Moscow/10/99 (H3N2)-like, A/New Caledonia/20/99 (H1N1)-like, and B/Beijing/184/93-like strain.
- Providing information on neuraminidase-inhibitor antiviral drugs.



- Providing a list of influenza control documents for special populations.<sup>1,2</sup>

National Adult Immunization Awareness Week (NAIAW), held annually in October, emphasizes the need for early immunization as the best measure to prevent influenza and its complications, while reminding adults of other important immunizations. For example, many patients eligible for the flu vaccine are also eligible for the pneumococcal vaccine. More information on adult immunizations can be found at <http://www.nfid.org/ncai/publications/naiaw-kit/>.

## CLINICAL FEATURES

Influenza A and B are the two types of influenza viruses that cause epidemic human disease. Influenza A viruses are further classified into subtypes on the basis of two surface antigens. Both viruses undergo continual antigenic change (drift and shift), resulting in different circulating virus strains each year. Although influenza can occur year round, the influenza season in the US is from November through April. Outbreaks of influenza reach a peak between late December and early March; they can begin earlier in Hawaii and Alaska and may continue into the spring in some areas. Influenza A epidemics usually last about eight weeks within a given community.<sup>2</sup>

The incubation period for influenza is one to four days with an average of two days. It is an acute respiratory-tract infection characterized by an abrupt onset and significant symptoms that can include fever, cough, chills, sore throat, headache, fatigue, nonproductive cough, rhinitis, and myalgias. Most infected persons recover completely in one to two weeks. However, in some persons influenza can exacerbate underlying medical conditions (e.g., pulmonary or cardiac disease). In addition, some persons will develop serious and life-threatening medical complications, such as secondary bacterial pneumonia or influenza viral pneumonia.<sup>2</sup> Other potential complications include otitis media in infants and young children, tracheobronchitis in adults with chronic lung disease, and acute sinusitis in all ages. Infrequent complications include myocarditis, pericarditis, thrombophlebitis, myositis, rhabdomyolysis, acute myoglobinuria, transverse myelitis, and Reye's syndrome.<sup>5</sup>

Diagnosis is usually made on clinical grounds, especially if influenza has been proven to be in circulation locally. Clinicians can rely on existing influenza surveillance systems to determine whether influenza is circulating in their geographic area (e.g., state) and what type is predominant. A weekly update can be obtained from the Centers for

Disease Control and Prevention at its Web site at <http://www.cdc.gov/ncidod/diseases/flu/weekly.htm>. The "Influenza Summary Update" is also available from CDC through an automated phone-and-fax system (call [888] 232-3299 and request fax document number 231100).

## THE INFLUENZA VACCINE

The influenza vaccine is a killed-virus vaccine. It is made from highly purified, egg-grown viruses that are inactivated so as to be noninfectious. Whole-virus, subviral, and purified-surface-antigen preparations are available. The vaccine contains three strains of influenza virus: two type A strains and one type B strain. The components of the vaccine are selected during the preceding winter. The three strains selected for inclusion in the vaccine each year represent the most likely viruses to circulate in the US in the upcoming winter.<sup>2</sup> Influenza vaccine from the previous season cannot be used because the composition of the vaccine changes annually.

The protection conferred by influenza vaccine generally begins one to two weeks after injection and may last six months or longer. In some elderly patients, serum antibody levels may fall below protective levels in four months or less. Therefore, the optimal administration time period is from October through mid-November, but any

| Age Group  | Product <sup>a</sup>  | Dose    | No. of Doses        | Route <sup>b</sup> |
|------------|-----------------------|---------|---------------------|--------------------|
| 6-35 mos.  | Split-virus only      | 0.25 ml | 1 or 2 <sup>c</sup> | Intramuscular      |
| 3- 8 yrs.  | Split-virus only      | 0.50 ml | 1 or 2 <sup>c</sup> | Intramuscular      |
| 9- 12 yrs. | Split-virus only      | 0.50 ml | 1                   | Intramuscular      |
| >12 yrs.   | Whole- or split-virus | 0.50 ml | 1                   | Intramuscular      |

**Notes:**

The vaccine dosage contains 15µg each of A/Moscow/10/99 (H3N2)-like, A/New Caledonia/20/99 (H1N1)-like, and B/Beijing 184/93-like antigens. For the A/Moscow/10/99 (H3N2)-like antigen, manufacturers will use the antigenically equivalent A/Panama/2007/99 (H3N2) virus, and for the B/Beijing/184/93-like antigen, US manufacturers will use the antigenically equivalent B/Yamanashi/166/98 virus because of their growth properties and because they are representative of currently circulating A (H3N2) and B viruses.

a. Because of their decreased potential for causing febrile reactions, only split-virus vaccines should be used for children. They might be labeled as split, subviral, or "purified-surface-antigen" vaccine. Immunogenicity and side effects of split- and whole-virus vaccines are similar among adults when vaccines are administered at the recommended dosages.

b. For adults and older children, the recommended site of vaccination is the deltoid muscle. The preferred site for infants and young children is the anterolateral aspect of the thigh.

c. Two doses administered at least 1 month apart are recommended for children <9 years of age who are receiving influenza vaccine for the first time.

Table 1. Influenza vaccine dosage, by age group—United States, 2000–2001 season.<sup>2</sup>

time from September to the end of the season is appropriate.<sup>6</sup>

The recommended dosage of the influenza vaccine is a single intramuscular (IM) 0.5-ml dose for adults and children at least three years old and 0.25 ml for children 6 to 35 months old. Children less than nine years old receiving influenza vaccine for the first time should receive two doses at least four weeks apart.<sup>6</sup> Table 1 shows the dosing regimen and vaccine type appropriate for each age group; Table 2 lists vaccine manufacturers. The clinician should record the date, time, site of administration, route of administration (i.e., IM), manufacturer, dosage and amount given, lot number, and name of person who administered the vaccine.

It is recommended that the patient be observed for 15 minutes after the injection for any possible severe reaction.<sup>6</sup> Adverse reactions are rare, except for soreness, erythema, and edema at the injection site for one or two days. When they do occur, systemic reactions include fever, malaise, and myalgias and most frequently affect persons such as young children who have not had previous exposure to the influenza virus antigens in the vaccine. These reactions generally begin 6 to 12 hours after vaccination and persist for one to two days.<sup>2</sup> Split-virus and purified-surface-antigen formulations are less likely to cause febrile reactions and should be used in children less than 13 years old.<sup>7</sup>

Immediate, presumably allergic, reactions can also occur. These include hives, angioedema, allergic asthma, and anaphylaxis. These are rare reactions that probably result from hypersensitivity to a vaccine component. The component most frequently implicated is the residual egg protein. Allergic reactions to the preservative, thimerosal (also the preservative in contact lens solution) have been reported.<sup>2</sup>

Guillain-Barre syndrome (GBS) was associated with the 1976 swine flu vaccine. Other than the swine flu vaccine, no large increase in GBS has been associated with the flu vaccine. Cases of GBS have been reported in patients who received the vaccine, but epidemiologic stud-



| Manufacturer                   | Brand     | Type of Vaccine          | Telephone Number |
|--------------------------------|-----------|--------------------------|------------------|
| Aventis Pasteur Inc.           | Fluzone   | whole- or split-virus    | (800) 822-2463   |
| Medeva Pharma Ltd.             | Fluvirin  | purified-surface-antigen | (800) 234-5535   |
| Parkedale Pharmaceuticals Inc. | Flugen    | split-virus              | (888) 358-6436   |
| Wyeth Lederle Laboratories     | Flushield | split-virus              | (800) 358-7443   |

Table 2. Influenza vaccine manufacturers.

ies have not shown a causal association.<sup>2</sup>

In discussing the potential side effects with patients, physicians should emphasize that the inactivated vaccine cannot cause influenza and that any coincident respiratory illness unrelated to the influenza viruses can occur after vaccination.<sup>2</sup>

The CDC and the FDA have developed a postmarketing safety surveillance program for vaccines, including the influenza vaccine. The Vaccine Adverse Event Reporting System (VAERS) collects and analyzes information from reports on possible adverse events after vaccination. Physicians should report any clinically significant adverse event that occurs after administration of any vaccine licensed in the US, even if it is uncertain that the adverse event is related to the immunization. Reports to VAERS can be made by calling (800) 822-7967.

Vaccine effectiveness depends primarily on the age and immunocompetence of the person receiving the vaccine. It also depends on the degree of similarity between the

viruses in the vaccine and the viruses in circulation. When the antigenic match between the viruses in the vaccine and the viruses in circulation is close, the vaccine prevents illness in approximately 70% to 90% of healthy persons less than 65 years old. The protection occurs because most vaccinated children and young adults develop high polyvaccination hemagglutination-inhibition antibody titers. These antibody titers are protective against strains similar to those in the vaccine.<sup>2</sup>

Elderly persons with certain chronic diseases may not develop adequate lower postimmunization antibody titers and remain susceptible to influenza-related infection. However, the vaccine may still be effective for these individuals to prevent secondary complications of influenza and reduce the risk of influenza-related hospitalization and death. Among elderly persons living outside of nursing homes or other similar chronic-care facilities, the vaccine is 30% to 70% effective in preventing hospitalization for pneumonia and influenza. Among

elderly persons living in nursing homes, the vaccine is 50% to 60% effective in preventing hospitalization or pneumonia and 80% effective in preventing death.<sup>2</sup>

The influenza vaccine can be given at the same time as other vaccines. The target groups for influenza and pneumococcal vaccine overlap considerably. Health care workers should offer the pneumococcal vaccine to their previously unvaccinated patients at the same time that they offer them the flu vaccine. The difference in the administration schedule is that the pneumococcal vaccine is not given annually and the flu vaccine is given annually.<sup>2</sup> If given at the same time, the two vaccines should be administered in separate arms with separate devices.

There are a few contraindications to receiving the influenza vaccine. The following groups of individuals should not be immunized:

- Persons previously immunized during the current influenza vaccination season.
- Anyone allergic to eggs or thimerosal (preservative in contact lens solution).

- Anyone who has had a previous severe reaction to influenza vaccine (e.g., anaphylactic shock).
- Anyone with a history of GBS.<sup>2</sup>

### Advisory Committee on Immunization Practices (ACIP) Influenza Vaccine Recommendations

Influenza vaccine is strongly recommended for persons aged six months and older who, because of age or underlying medical condition, are at increased risk for influenza complications. In addition, health care workers and other individuals (including household members) in close contact with persons in high-risk groups should be vaccinated to decrease the risk of transmission. The vaccine can also be administered to anyone aged greater than or equal to six months to reduce the chance of becoming infected with influenza.<sup>2</sup>

#### Increased Risk of Complications.

The target groups for vaccination because they have an increased risk of complications are:

- Persons aged 50 years old and older.
- Residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions.
- Adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including asthma.
- Adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications).
- Children and teenagers (aged 6 months to 18 years) who are receiving long-term aspirin therapy and therefore might be at increased risk for developing Reye's syndrome after influenza infection.
- Women who will be in the second or third trimester of pregnancy during the influenza season (vaccine should be administered in consultation with their obstetrical provider).<sup>2</sup>

#### Increased Risk of Transmission.

The target groups for vaccination because they have an increased risk of transmitting influenza to those at high risk are:

- Physicians, nurses, and other personnel in both hospital and outpatient-care settings, including emergency response workers.
- Employees of nursing homes and chronic-care facilities who have close contact with patients or residents.
- Employees of assisted-living and other residences for persons in high-risk groups.
- Persons who provide home care to persons in high-risk groups.
- Household members (including children) of persons in high-risk groups.<sup>2</sup>

Despite these recommendations and the vaccine's safety, immunization rates remain low among high-risk groups. Physicians may want to consider using standing orders for influenza immunization to streamline the process in their offices. The Peer Review Organization of New Jersey (PRO) has developed an "Influenza Assessment and Order Form" for this purpose. Copies can be ordered by calling the PRO's information line at (800) 624-4557, weekdays between 9 AM and 5 PM.

If a patient declines the vaccine but is considered high-risk, the provider should document the reason for refusal. The physician should also discuss the flu vaccine with patients who initially refused the vaccine on subsequent visits during the flu season. Some people change their mind as flu season progresses and opt to receive the vaccine. Other patients may opt to receive the flu vaccine from their local health department, visiting nurses association, or other mass immunization clinic usually offered



from October through December. Providers can check with their local health departments for schedules.

### **ACIP Influenza Vaccine Recommendations Due to Potential Delay**

For the 2000-2001 flu season, doses of influenza vaccine are likely to be delayed. Resolution of the manufacturing problems and improved yields of a vaccine component averted a shortage. The number of vaccine doses available for this season is currently estimated at 75 million doses compared with the approximately 74 million doses that were distributed to providers for the 1999-2000 flu season. In light of the potential delay, the ACIP has modified its influenza vaccination recommendations for the 2000-2001 influenza season. It is important to note that the revised recommendations are for the 2000-2001 season only, in response to the anticipated vaccine delay.<sup>8,9</sup> Because the 2000-2001 vaccine differs from the 1999-2000 vaccine, vaccine supplies of the 1999-2000 vaccine should not be used. As with any other pharmaceutical agent, the product label, package insert, and *Physicians' Desk Reference* should be reviewed prior to administration.<sup>1,9,10</sup>

The CDC and the New Jersey Department of Health and Senior Services (NJDHSS) have requested that mass community flu vaccine

clinics should be delayed until mid-November to avoid cancellation of a clinic due to unavailability of vaccine.<sup>1</sup> These clinics are encouraged to consider being scheduled through December, or later, based on vaccine availability and local need. Influenza immunizations can also be obtained through physician offices, pending vaccine availability at their office.

The revised influenza recommendations for the 2000-2001 season identify that the following target groups in their list of persons at high risk for complications from influenza receive the vaccine first. Persons with HIV and their household members are among the high-risk groups recommended to receive the vaccine when it becomes available.<sup>1</sup> Because influenza immunization can result in the production of protective antibody titers, vaccination benefits many persons with HIV.<sup>2</sup> Health care personnel and employees of hospitals, clinics, offices, and chronic-care institutions who have close contact with persons in high-risk groups are also a priority group for immunization. The entire list of persons recommended to receive the vaccine as a priority include the following:<sup>1,8,9</sup>

- Persons aged 65 years and older, including inpatients as required by state licensure standards.
- Residents of nursing homes and other chronic-care facilities that

house persons of any age whom have chronic medical conditions.

- Adults and children who have chronic disorders of the pulmonary or cardiovascular system, including asthma.
- Adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications).
- Children and teenagers (aged 6 months to 18 years) who are receiving long-term aspirin therapy.
- Women who will be in the second or third trimester of pregnancy during the influenza season in consultation with their obstetrical provider.

When the vaccine is available, vaccination efforts should focus on persons at high risk for complications associated with influenza disease and on health care workers who care for these persons. Temporary shortages due to delayed or partial shipments may require decisions on how to assign priority to the use of vaccine available early in the season among high-risk persons and health care workers. Such decisions are best made with those familiar with the local situation. Because vaccine sup-

plies are anticipated to increase substantially in November and December, plans should be made to continue vaccination of high-risk persons and health care workers into December and later.<sup>9</sup>

Information about vaccine supply, influenza activities, and copies of the ACIP recommendations can be obtained by calling the CDC National Immunization Hotline at (800) 232-2522 or from the Web at <http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/444903a1.htm> or <http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/mm4927a4.htm>. The NJDHSS will also monitor the situation and keep the health care community advised through the LINC system if changes occur. Information about influenza clinics in an area can be obtained from the local health department and New Jersey's Office of Information Technology.

### **Hospital and Long-Term Care Facility Influenza Immunization Licensure Requirements**

The NJDHSS adopted new regulations in 1999 concerning influenza vaccination of hospitalized patients 65 years of age and older. The hospital licensure standards, NJAC 8:43G-14.6, require that "between October 1 and February 1 of every year, provided a patient's medical condition permits, every patient aged 65 or older shall be

provided the opportunity to receive vaccination against influenza. Receipt of the vaccination shall be documented on the patient's chart and made part of the patient's permanent hospital record. Prior to administration of the vaccination, diligence shall be exercised to determine whether the patient has already received the influenza vaccination for the year in question. Patients refusing the influenza vaccine(s) shall be requested to sign a form indicating that the vaccine was offered, but refused."<sup>11</sup> A similar regulation went into effect in 1998 for patients in long-term care facilities.<sup>12</sup>

### **INFLUENZA TREATMENT**

#### **Neuraminidase-Inhibitor Antiviral Drugs**

Four antiviral agents have been FDA approved to treat acute, uncomplicated influenza. Amantadine and rimantadine are active against and have been approved for use as prophylaxis against influenza A. Zanamivir and oseltamivir are active against both influenza A and influenza B but have not been approved for prophylaxis. All four drugs are designed to be given in the initial stages of influenza, within one or two days at most from the onset of symptoms.<sup>13</sup> These drugs are not a substitute for vaccine, and the ACIP does not support their general use for prophylaxis for most

people, even if an influenza vaccine shortage develops. Widespread use of these agents for prophylaxis could result in large numbers of people experiencing adverse effects and could result in the development and spread of substantial numbers of drug-resistant influenza viruses.<sup>1</sup>

Zanamivir and oseltamivir are in no way intended to replace or supplant the influenza vaccine. Although some elderly persons may develop symptoms of influenza despite being vaccinated, influenza vaccine has been shown to substantially decrease the risk of hospitalization and death due to influenza. Vaccination may also prevent epidemics in nursing homes by conferring herd immunity.<sup>13</sup>

In January 2000 the FDA issued a public health advisory on safe and appropriate use of influenza drugs, reminding prescribers of important clinical decisions that need to be made when they are considering use of antiviral drugs for treatment of patients with signs and symptoms of influenza.<sup>13</sup> It is important to identify patients who are appropriate candidates for antiviral therapy and recognize patients who may be at risk for serious adverse outcomes from other noninfluenza diagnoses or from adverse events potentially related to antiinfluenza therapy. Salient points include the following:



| Name of Drug                         | Manufacturer              | Brand                      | Telephone Number |
|--------------------------------------|---------------------------|----------------------------|------------------|
| Amantadine                           | Endo Pharmaceuticals      | Symmetre—tablet and syrup  | (800) 462-3636   |
| Also available in generic form from: |                           |                            |                  |
|                                      | Invamed                   | Amantadine HCL—capsule     |                  |
|                                      | Rosemont                  | Amantadine HCL—capsule     |                  |
|                                      | Alpharma                  | Amantadine HCL—syrup       |                  |
|                                      | Copley Pharmaceutical     | Amantadine HCL—syrup       |                  |
|                                      | HiTech Pharma             | Amantadine HCL—syrup       |                  |
|                                      | Mikart                    | Amantadine HCL—syrup       |                  |
|                                      | Morton Grove              | Amantadine HCL—syrup       |                  |
|                                      | Pharmaceutical Associates | Amantadine HCL—syrup       |                  |
| Rimantadine                          | Forest Laboratories       | Flumadine—tablet and syrup | (800) 678-1605   |
| Zanamivir                            | Glaxo Wellcome            | Relenza—inhaled powder     | (800) 825-5249   |
| Oseltamivir                          | Hoffmann-LaRoche          | Tamiflu—tablet             | (800) 526-6367   |

Table 3. Antiviral influenza drug manufacturers.

- Vaccination remains the primary method of preventing and controlling influenza.
- The possibility of primary or concomitant bacterial infection should always be considered when a physician is making treatment decisions for patients with suspected influenza.
- Special caution is needed in prescribing zanamivir to patients with underlying asthma or chronic obstructive pulmonary disease (COPD).<sup>13</sup>

When initiation of antiviral therapy alone is considered on a presumptive basis, ongoing clinical assessment and diagnostic evaluation

of the patient continues to be important. The FDA has received several reports of patients with serious bacterial infections who initially had influenzalike symptoms and whose bacterial infections progressed during treatment with antiviral drugs alone. Patients with severe influenzalike illness, especially patients with chronic medical conditions or complicated manifestations of acute illness, might have significant bacterial infections instead of, or in addition to, viral illness. Appropriate antibacterial therapy should be initiated whenever bacterial infection is suspected.<sup>13</sup>

The FDA indicates it has received several reports of deterioration of respiratory function following inhalation of zanamivir in patients with underlying asthma or COPD. Casual relationships with drug therapy are extremely difficult to evaluate in the setting of complex medical processes, but the possibility cannot be excluded that an acute decline in respiratory function may contribute to a fatal outcome in patients with complicated preexisting medical history and pulmonary compromise. The zanamivir package insert contains important precautionary information regarding risks of bronchospasm in patients with

| Antiviral Agent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Age Group (in years)                                             |                                    |                                   |                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------|-----------------------------------|--------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1-9                                                              | 10-13                              | 14-64                             | >65                            |
| <b>Amantadine<sup>a</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  |                                    |                                   |                                |
| Treatment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 5 mg/kg/day<br>Up to 150 mg <sup>b</sup><br>in two divided doses | 100 mg<br>twice daily <sup>c</sup> | 100 mg<br>twice daily             | ≤100 mg/day                    |
| Prophylaxis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5 mg/kg/day<br>Up to 150 mg <sup>b</sup><br>in two divided doses | 100 mg<br>twice daily <sup>c</sup> | 100 mg<br>twice daily             | ≤100 mg/day                    |
| <b>Rimantadine<sup>d</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                  |                                    |                                   |                                |
| Treatment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Not applicable                                                   | Not applicable                     | 100 mg<br>twice daily             | 100 or 200 mg/day <sup>e</sup> |
| Prophylaxis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5 mg/kg/day<br>Up to 150 mg <sup>†</sup><br>in two divided doses | 100 mg<br>twice daily <sup>c</sup> | 100 mg<br>twice daily             | 100 or 200 mg/day <sup>e</sup> |
| <b>Zanamivir<sup>g</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                  |                                    |                                   |                                |
| Treatment <sup>f</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Not applicable                                                   | 10 mg <sup>f</sup><br>twice daily  | 10 mg<br>twice daily              | 10 mg<br>twice daily           |
| Prophylaxis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Not applicable                                                   | Not applicable                     | Not applicable                    | Not applicable                 |
| <b>Oseltamivir<sup>g</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                  |                                    |                                   |                                |
| Treatment <sup>h</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Not applicable                                                   | Not applicable                     | 75 mg <sup>h</sup><br>twice daily | 75 mg<br>twice daily           |
| Prophylaxis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Not applicable                                                   | Not applicable                     | Not applicable                    | Not applicable                 |
| <b>Notes:</b><br>a. Consult the drug package insert for dosage recommendations for administering amantadine to persons with creatinine clearance ≤50 mL/min/1.73m <sup>2</sup> .<br>b. 5 mg/kg of amantadine or rimantadine syrup = 1 tsp/22 lbs.<br>c. Children ≥10 years of age who weigh <40 kg should be administered amantadine or rimantadine at a dosage of 5 mg/kg/day.<br>d. A reduction in dosage to 1000 mg/day of rimantadine is recommended for persons who have severe hepatic dysfunction or those with creatinine clearance ≤10mL/min. Other persons with less severe hepatic or renal dysfunction taking 100 mg/day of rimantadine should be observed closely, and the dosage should be reduced or the drug discontinued, if necessary.<br>e. Elderly nursing home residents should be administered only 100 mg/day of rimantadine. A reduction in dosage to 100 mg/day should be considered for all persons ≥65 years of age if they experience possible side effects when taking 200 mg/day.<br>f. Zanamivir is approved for persons >12 years of age and is administered as two 5-mg inhalations of medicated powder twice a day (i.e., 20 mg twice a day). The medication is administered via inhalation using a plastic device included in the package with the medication. Patients will benefit from instruction and demonstration of proper use of the device.<br>g. Neither zanamivir nor oseltamivir are approved for prophylaxis.<br>h. Oseltamivir is approved for persons >18 years of age. A reduction in the dose of oseltamivir is recommended for persons with creatinine clearance <30 mL/min. |                                                                  |                                    |                                   |                                |

Table 4. Recommended daily dosage of influenza antiviral medications for treatment and prophylaxis.



underlying airway disease and the lack of proven efficacy in such persons. If a decision is made to prescribe zanamivir for a patient with underlying airway disease, it should be used under conditions of careful monitoring, proper observation, and appropriate supportive care, including the availability of short-acting bronchodilators.<sup>13</sup>

The evidence for use of antiviral drugs to treat influenza is based principally on studies of patients with uncomplicated influenza. There is no clear evidence for safety and efficacy in persons with underlying respiratory or cardiac diseases or in persons with complications of an acute influenza episode (e.g., viral or bacterial pneumonia). Such patients may require extensive supportive and adjunctive care. Antiviral therapy has not been shown to reduce the need for such care and monitoring.<sup>13</sup> All health care professionals are encouraged to report any serious adverse event associated with the use of antiviral drugs for influenza to the FDA's MedWatch program at (800) FDA-1088 [fax (800) FDA-0178], or to the respective pharmaceutical manufacturers (see Table 3).

Table 4 shows the recommended daily dosage of influenza antiviral medications for treatment and prophylaxis.

## ACKNOWLEDGMENT

The authors would like to acknowledge the assistance of Eddy

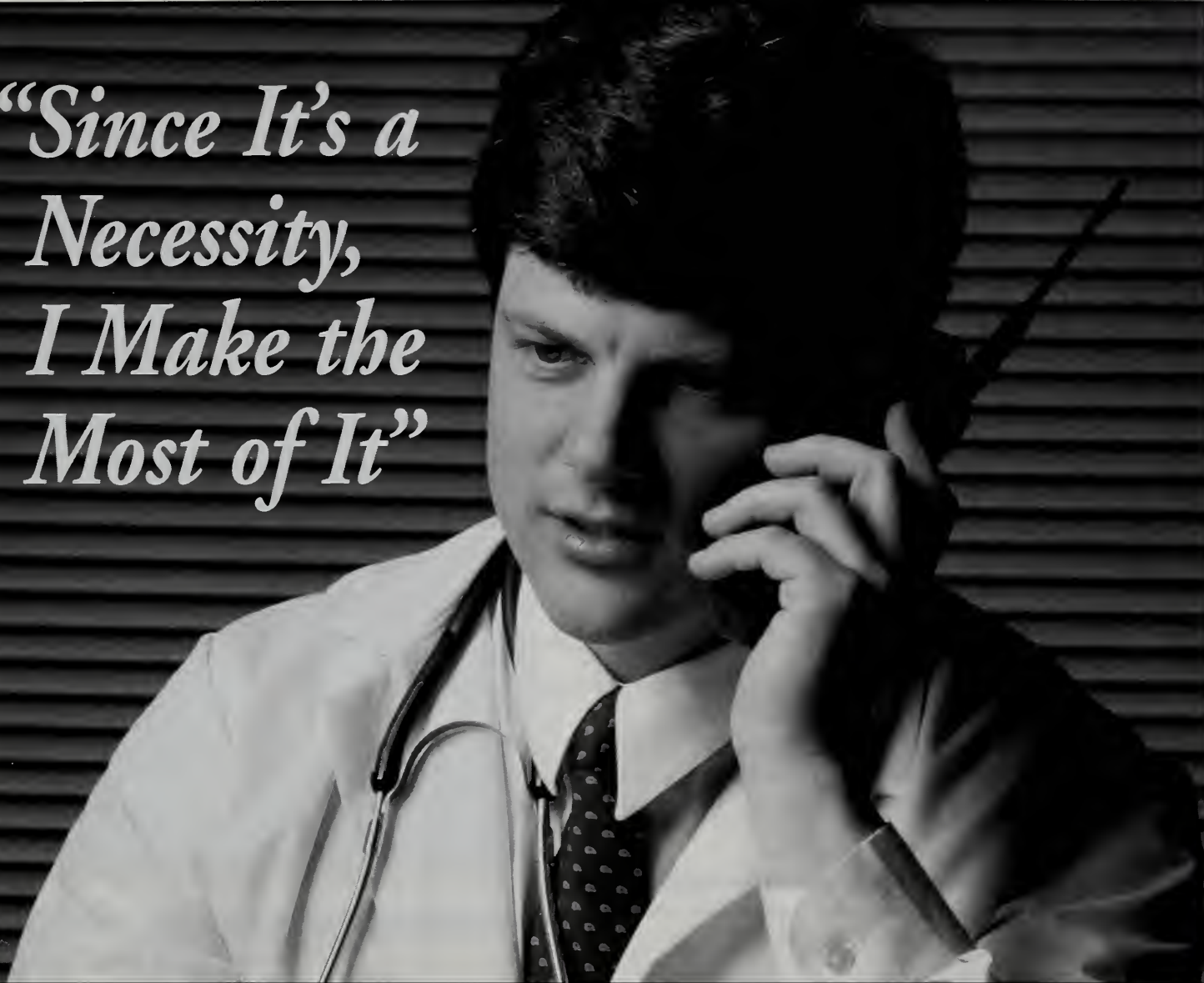
Bresnitz, MD, MPH, state epidemiologist, and Charles O'Donnell, MPA, chief, New Jersey Immunization Program, in the preparation of this manuscript.

Jamie L. Reedy is assistant professor, Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School; Cindy Paul is medical director, Division of AIDS Prevention and Control, New Jersey Department of Health and Senior Services; and Martin Zanna is medical consultant, New Jersey Department of Health and Senior Services.

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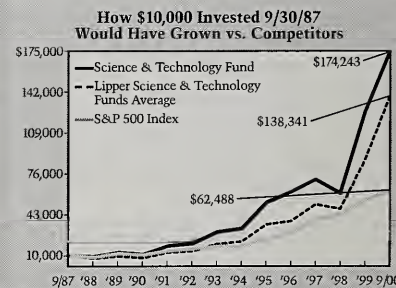
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# Osteoporosis

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## Recommended Guidelines and New Jersey Legislation

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MORE THAN 28 MILLION AMERICANS AGED 50 AND OVER HAVE OSTEOPOROSIS OR LOW BONE DENSITY. WHILE 80% OF THOSE AFFECTED ARE WOMEN, ONE IN EIGHT MEN ALSO SUFFER FROM THE DISEASE. THIS NUMBER IS EXPECTED TO INCREASE AS MEN LIVE LONGER. COMMONLY CALLED THE "SILENT DISEASE," OSTEOPOROSIS EXHIBITS NO SYMPTOMS OR PAIN UNTIL A FRACTURE OCCURS. THE MOST COMMON FRACTURES INVOLVE THE WRIST, VERTEBRA, AND HIP. HALF OF ALL WOMEN AND 20% OF MEN WILL HAVE AT LEAST ONE OSTEOPOROSIS FRACTURE IN THEIR LIFETIME. THIS ARTICLE DESCRIBES STATEWIDE EFFORTS TO PREVENT AND MANAGE OSTEOPOROSIS AND THE RECOMMENDED PRACTICE GUIDELINES FOR THE DIAGNOSIS AND TREATMENT OF THE DISEASE.

*Sue A. Shapses, PhD; Marjorie M. Luckey, MD; Jeffrey P. Levine, MD, MPH; Julie K. Timins, MD, FACR; and Geraldine M. Mackenzie, MSS, MLSP*

**D**isability from osteoporosis-related fractures places heavy demands on the health care system. The National Osteoporosis Foundation reports that in 1995 osteoporotic fractures were the cause of 432,000 hospital admissions, almost 2.5 million physician visits, and 180,000 nursing home admissions in the United States. Direct medical expenditures for osteoporotic fractures that year were estimated at \$13.8 billion. The outcome of hip fractures in the elderly is particularly alarming: 20% of patients require long-term nursing home care, 50% never regain their ability to walk independently, and 20% die within one year due to

complications from the fracture or associated surgery.<sup>1</sup> In addition, osteoporosis often diminishes the quality of life, causes chronic pain, impairs mobility, and adversely affects physical, psychological, and social status.

### THE INTERAGENCY COUNCIL ON OSTEOPOROSIS (ICO)

#### The New Jersey Response

In 1997 the Osteoporosis Prevention and Education Act was passed (Public Law 1997, Chapter 191). This established an osteoporosis program under the supervision of the Department of Health and Senior Services (DHSS). A primary goal of the program is to educate the public about the causes of osteo-

porosis, prevention strategies, the value of early detection, and treatment options. Mandated activities under the act include development of a public education and outreach campaign; development of educational materials for consumers, health professionals, and community organizations; development of professional education programs for health care providers; and the development and maintenance of a list of current providers of specialized services for the prevention and treatment of osteoporosis.

#### ICO Projects and Programs

A variety of osteoporosis-related activities are funded and administered through DHSS. In 1998 a



monograph on *Recommended Practice Guidelines for the Diagnosis and Treatment of Osteoporosis* was issued and approved for Category I continuing medical education credit.<sup>2</sup> A current project is the development of a brochure for consumer education to be distributed at pharmacies throughout the state.

The majority of ICO initiatives are provided through partnership with other agencies, corporations, coalitions from industry and the public sector, and the help of dedicated individuals. Throughout 1999 a series of intergenerational programs were offered at New Jersey malls. These events included a physical activity component, presentations by New Jersey physicians, and interactive booths where individuals and families could obtain information on the prevention, diagnosis, and treatment of osteoporosis. Other community activities include the administration of Project Healthy Bones, an exercise and education program for older adults, and the development and distribution of videotapes and curricula for children in grades five through eight.

### Focus on Physicians

One of the ICO's current educational efforts focuses on physicians. For the year 2000, this included a lecture and exhibition booth at the New Jersey Physicians Conference 2000 and a newly developed "Osteoporosis Risk Assessment and Fact Sheet" that is available for physicians to provide to their patients.

## RECOMMENDED GUIDELINES FOR OSTEOPOROSIS: DIAGNOSIS AND TREATMENT

Bone density is currently the single most important determinant for fracture risk and is inversely proportional to fracture risk. The propensity to fall in the elderly is also a significant factor. Bone density is determined by the initial peak bone mass and subsequent rates of bone loss. Peak bone mass is usually attained by the third decade of life, men having a higher bone mass than women. During the first three to five years of menopause, there is a rapid decline in bone density; and bone loss can reach up to 30% of a woman's total bone mineral density (BMD) during the first decade after menopause. Both men and women continue to lose bone mass, from 0.5% to 1% per year, for the remainder of their lives.

### DIAGNOSIS

Like many chronic diseases, osteoporosis is often not diagnosed until clinical symptoms occur. However, because fractures usually indicate advanced disease, it is important to diagnose osteoporosis *before* a fracture occurs. This is especially pertinent in view of the excessively high risk for a second fracture and the wide range of available and effective therapeutic agents.

### Risk Factor Assessment

Risk factor assessment is not a reliable method for diagnosing osteoporosis in the absence of bone mass measurements. However, risk factor assessment and/or abnormalities on X ray may indicate the need to perform densitometry.

Key risk factors for osteoporotic fracture are:

- Personal history of low impact fracture as an adult (fall from one step or less).
- History of osteoporotic fracture in a first-degree relative.
- Current cigarette smoking.
- Body weight of less than 127 lbs.

Other risk factors include:

- European or Asian ethnicity.
- Advanced age.
- Female sex.
- Estrogen deficiency.
- Early menopause (less than 45 years of age) or bilateral ovariectomy.
- Prolonged premenopausal amenorrhea (more than one year).
- Low calcium intake (lifelong).
- Alcoholism.
- Impaired eyesight despite adequate correction.
- Recurrent falls.
- Inadequate physical activity.
- Poor health/frailty.
- Long-term use of certain medications for conditions such as asthma, arthritis, and cancer (i.e., glucocorticoids, phenytoin, excessive thyroxine).

### Bone Densitometry

The measurement of BMD is the single best diagnostic tool when osteoporosis is suspected. Prospective studies show that each standard deviation (approximately 10% to 13%) decrease in BMD increases the relative risk of fracture by one and a half to three times. Bone density testing is now covered by Medicare for:

- All estrogen-deficient women at risk for osteoporosis.

- Individuals (men or women) with osteopenia or vertebral deformities on X ray.
- Individuals receiving glucocorticoid therapy (e.g., 7.5mg or more of prednisone per day for more than three months).
- Individuals with hyperparathyroidism.
- Monitoring FDA-approved osteoporosis drug therapy.

### Diagnostic Criteria

The World Health Organization (WHO) has established BMD diagnostic guidelines for the interpretation of bone mass measurement in postmenopausal white women. The T-score is defined as the number of standard deviations from the USA reference population, women between the ages of 20 and 35 years. This value is used to estimate fracture risk and to diagnose osteoporosis. Values are as follows:

- Normal—BMD not more than 1 standard deviation (SD) below the mean value of peak bone mass in young normal women.
- Low bone mass (or osteopenia)—BMD between 1 SD and 2.5 SD below the mean for young normal women.
- Osteoporosis—BMD more than 2.5 SD below the mean for young normal women.
- Severe osteoporosis—BMD more than 2.5 SD below the mean value of peak bone mass in young normal women and the presence of insufficiency fractures.

Treatment is generally recommended for all postmenopausal women with osteoporosis. Post-

menopausal women with osteopenia who have other risk factors for fractures (e.g., personal history of fractures, weight of less than 127 lbs, high risk of falls, or a family history of osteoporotic hip or vertebra fracture) may also need treatment and/or behavior and diet modification.

### Methods

Options for measurement include either peripheral skeletal sites (forearm, heel, and finger) or central sites (hip and spine) or both. In most countries, dual energy X-ray absorptiometry (DXA) of central sites is the most widely used technique. DXA is considered the gold standard in view of its precision, low radiation exposure, and capacity to measure multiple skeletal sites, especially those at greatest risk for osteoporotic fracture, the spine and hip. Measurement of at least two skeletal sites is preferred because bone density may vary between skeletal sites even in the same individual. However, other techniques that measure a single site, such as quantitative computerized tomography, peripheral X-ray techniques,

and ultrasound, are also available for bone density measurements.

## MANAGEMENT

### Treatment Goals

Treatment goals in the management of osteoporosis are to:

- Prevent fractures.
- Stabilize/minimize bone loss and attempt to increase bone mass.
- Relieve symptoms of fractures and skeletal deformity.
- Maintain or maximize physical function.

### Nutritional Considerations

Emphasis should be placed on nutrition education and developing good eating habits in children and young adults. A high intake of calcium in childhood and adolescence probably increases peak bone mass. The main focus on increasing calcium intake should be food first, with supplements appropriate if the diet is inadequate. In adults, adequate calcium intake in the range of 1,000mg to 1,200mg per day (see Table 1), along with sufficient vitamin D (about 400 IU daily), are fundamental to both prevention and treatment of osteoporosis. Adequate

| Age Group           | Adequate intake (mg/day) |
|---------------------|--------------------------|
| 1 through 3 years   | 500                      |
| 4 through 8 years   | 800                      |
| 9 through 18 years  | 1,300                    |
| 19 through 50 years | 1,000                    |
| 51+ years           | 1,200                    |

Table 1. Dietary Reference Intake for Calcium (1997). Partial List for Males and Females (Values do not Differ During Pregnancy and Lactation).



| Prevention                                                                                                                            | Treatment                                       |
|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| Hormone replacement therapy                                                                                                           | Hormone replacement therapy                     |
| Alendronate <sup>1</sup> (5mg/day)                                                                                                    | Alendronate <sup>1</sup> (10mg/day)             |
| Raloxifene <sup>2</sup> (60mg/day)                                                                                                    | Calcitonin <sup>3</sup> (200 IU/day intranasal) |
| Risedronate <sup>4</sup> (5mg/day)                                                                                                    | Raloxifene <sup>2</sup> (60mg/day)              |
|                                                                                                                                       | Risedronate <sup>4</sup> (5mg/day)              |
| Adequate calcium and vitamin D is recommended with all agents listed for both the prevention and treatment of osteoporosis.           |                                                 |
| 1. Fosamax.                                                                                                                           |                                                 |
| 2. Evista.                                                                                                                            |                                                 |
| 3. Miacalcin.                                                                                                                         |                                                 |
| 4. Actonel.                                                                                                                           |                                                 |
| Source: National Osteoporosis Foundation. <i>Physician's Guide to Prevention and Treatment of Osteoporosis</i> . Washington DC: 1998. |                                                 |

Table 2. Therapeutic Agents for Osteoporosis (FDA Approved).

vitamin D, especially in the winter months or for those who do not get adequate exposure to sunlight, is critical in preventing bone loss and reducing fractures. Referral to a registered dietitian may be useful in patients with dietary restrictions or underlying diseases for specific nutrient recommendations and nutrition counseling.

## Fall Prevention

Although increased bone fragility due to low bone mass is the single most important fracture determinant, it is not the sole determinant. Prevention of falls is important. Risk factors for falls in the elderly include:

- Arthritis of any lower extremity joint(s).
- Weakness due to any cause (e.g., rheumatologic or neurologic diseases).

- Dizziness or vertigo.
- Use of sedatives, hypnotics, narcotics, or polypharmacy.
- Visual impairment.

Prevention of falls can be achieved by correcting vision, wearing proper footwear, and using an assistive device, such as a cane or walker, if needed. A safe home environment is also important in preventing falls.

## Exercise

Exercise has a dual role in osteoporosis. It may stabilize or increase bone mineral density (BMD). Exercise can also strengthen and improve mobility, thereby assisting in the prevention of falls and subsequent fractures. The types of exercise that should be carried out will depend on whether prevention is the goal or if the person already has established osteoporosis. For long-

term prevention, most types of weight-bearing exercise will be helpful, including high-impact activities such as jogging, jumping, and racket sports. For the individual with osteoporosis, a more limited repertoire of exercises, such as walking or isometric or extension exercises, should be prescribed. After a fracture, osteoporotic patients should remain active and out of bed as much as possible to prevent the rapid loss of bone associated with bed rest. Referral to a physical therapist or a rehabilitation specialist may be helpful for more specific instructions.

## THERAPEUTIC AGENTS

Besides calcium and vitamin D, which do not require Food and Drug Administration (FDA) approval, there are therapeutic antiosteoporotic agents that may increase bone mass and subsequently reduce the incidence of fracture. Hormone replacement therapy (HRT), selective estrogen receptor modulators (SERMs, such as raloxifene), bisphosphonates (e.g., alendronate and risedronate), and calcitonin are FDA-approved for the prevention or treatment of osteoporosis (see Table 2).

HRT is indicated for the prevention of osteoporosis in postmenopausal women who do not have contraindications to its use. HRT leads to an increase in BMD in most postmenopausal women. Epidemiological studies suggest that estrogen prevents fracture, but no large prospective studies of fracture pre-

vention are available. HRT also minimizes symptoms associated with menopause (e.g., hot flashes, vaginal dryness). Its effect on coronary artery disease is still under evaluation. Possible side effects of HRT include menstrual-like side effects, slight increase in risk of thromboembolism, and possible increase in risk for breast cancer with prolonged use. Patients with an intact uterus usually require a combination of estrogen and progesterone to prevent endometrial hyperplasia or cancer.

SERMs are formulated to exert estrogenlike effects on some tissues, such as bone, while inhibiting estrogen actions in other tissues. One SERM, raloxifene, leads to a small increase in bone density, reduces vertebra fracture risk and LDL cholesterol, and has no adverse effects on the uterus or breast. Raloxifene may, however, exacerbate vasomotor symptoms and has the same risk of thromboembolism as oral estrogen.

Alendronate sodium and risedronate sodium are bisphosphonates (nonhormonal options) that increase BMD and reduce fracture risk of the vertebrae and femurs in postmenopausal women with osteoporosis. Side effects of alendronate are not frequent, but esophageal erosion may occur, especially if the medication is taken improperly. While risedronate has only recently become available for public use, side effects are currently considered minimal.

Salmon calcitonin is indicated only in women who are more than five years past menopause and is available as an intranasal spray. Side effects are uncommon. A small increase in BMD and reduction in fracture risk has been demonstrated in the spine, but not the hip.

There is still insufficient data to firmly establish an additive beneficial effect on reduced fracture risk resulting from the concomitant use of two or more classes of drugs or pharmaceuticals.

## SUMMARY

The management of osteoporosis should include a comprehensive program that includes nutritional considerations, fall prevention, exercise or physical therapy measures, and the use of specific antiosteoporotic therapeutic agents. There is currently no specialty or subspecialty training program dealing specifically with osteoporosis. Physicians and other health care professionals all have a role in the diagnosis and management of osteoporosis.

New Jersey is recognized as a leader in the field of osteoporosis prevention and educational programs. This distinction can be attributed directly to the commitment of those individuals, corporations, and agencies involved in the work of the ICO and its subcommittees. Ongoing efforts are needed to prevent and treat this disabling disease and to educate both physicians and the public on prevention, diagnosis, and treatment

options. Those interested in learning more about the ICO or in obtaining information about osteoporosis, including the risk assessment brochure, are encouraged to call (609) 588-3466.

*Sue A. Shapses is an associate professor in the Department of Nutritional Sciences at Rutgers University. Marjorie M. Luckey is medical director at Saint Barnabas Osteoporosis and Metabolic Bone Disease Center. Jeffrey P. Levine is an assistant professor in the Department of Family Medicine at UMDNJ-Robert Wood Johnson Medical School. Julie K. Timins is diagnostic radiologist at JFK Medical Center, Edison, and Christ Hospital, Jersey City; past president of the Radiological Society of NJ; chair, MSNJ Council on Communications; and member, MSNJ Council on Medical Services. Geraldine M. Mackenzie is coordinator of wellness programs at the New Jersey Department of Health and Senior Services.*

## REFERENCES\*

1. National Osteoporosis Foundation. *Physician's Guide to Prevention and Treatment of Osteoporosis*. Washington DC: 1998.
2. The Osteoporosis Coalition of New Jersey and The New Jersey Department of Health and Senior Services. Adelizzi RA and Shapses SA, eds. *Recommended Practice Guidelines for the Diagnosis and Treatment of Osteoporosis*, New Jersey, 1998.

\*For more information, contact The Osteoporosis Coalition of New Jersey, c/o NJ Department of Health & Senior Services, PO Box 364, Trenton NJ 08625-0364.



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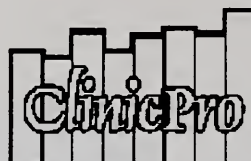
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# Death Foretold:

## Prophecy and Prognosis in Medical Care

Nicholas Christakis

Chicago: University of Chicago Press, 2000

307 pp., \$30.00

ISBN: 0226104702

Physicians are naturally cautious and reluctant to predict outcomes in an uncertain future. Should the doctor be wrong, consequences may include a breach of trust, embarrassment, or, conceivably, a lawsuit.

In *Death Foretold*, author Nicholas Christakis, MD, PhD, MPH, an associate professor of medicine and sociology at the University of Chicago, posits three major functions of medicine. Described as diagnosis, prognosis, and therapy, one of these—prognosis—is rarely or never explored during interactions with patients. Physicians, he proposes, avoid prognostication out of fear of uncertainty or a simple wish to avoid sharing bad news.

The very first lines of this book set the tone: "Predicting the outcome of life-threatening illness is never inconsequential or insignificant, for the patient or the doctor. Will the outcome be survival or death? What kind of death? When will it occur? How might therapy affect the outcome?" These are difficult questions to answer. And the difficulty is compounded when we realize that each patient has a different personality, a different mood, and different cognitive levels. There are different illnesses and different stages of illness. Add to this mixture constantly changing therapies, medications, costs, and managed care. No wonder prognostication is problematic.

The author expresses the view that prognosis and prognostic encounters with patients and families are not part of the formal training of medical students or resident physicians. Medical textbooks and journals appear to contain minimal material on prognostication. The process can be influenced by emotion. Christakis investigates the complexities of prognostication from the diverse standpoints of the history of medicine to the conduct of an analytic survey.

Individual chapters reiterate problems that physicians have with prognostication and examine them from different perspectives. Prognosis is examined as an explicit interaction that may influence the



outcome of a person's illness. A good prognosis may empower patients to better manage their personal affairs but a poor prognosis may lead one to "give up." There are circumstances where prognosis is required—for example, by a family dealing with the challenges of an individual with Alzheimer's disease. Patients with hypercholesterolemia or hypertension want to know their risk factors and longevity. Omission of prognostic considerations can be detrimental, as in cases of terminal illness where decisions need to be made about nursing care, medical costs, and insurance. Knowledge of the prognosis may shift care from a curative to a palliative approach.

"Errors are unavoidable in prognostication," admits the author, and this knowledge influences the patient as well as the physician's colleagues. He explores the many consequences: the patient's feelings of being misinformed, the possibility of litigation, and the issue of accountability. Physicians may use techniques such as delay or avoidance, ambiguity, and optimism or pessimism, depending on the circumstances. Physicians may feel

obligated to explain the reasons for error in prognosis.

"Physicians regard prognostication with anxiety and disdain," says the author. Prognostications are complex and difficult to formulate and may be the most challenging part of the physician's practice. Doctors feel there is an inherent uncertainty in predicting the future. They experience stressful responses even if the prognosis is certain but unfavorable, and being obligated to communicate it face to face with the patient makes that response even more acute. In addition, most physicians, because of a lack of specific training in the art of prognostication, find difficulty "maintaining hope, being honest, and being accurate."

Some doctors feel that "predictions can affect outcomes through a kind of self-fulfilling prophecy." By that, the author means the prediction can change the patient's attitude, behavior, and physiology in such a way that a predicted outcome may result. He provides numerous anecdotes to illustrate this belief.

The solution? When performing the art of prognostication, the

author indicates, physicians should communicate slowly and deliberately. Truth, accuracy, and empathy preserve hope. Optimistic prognoses should be supported by illustrative examples. Communication of bad news is perhaps best accomplished in stages, to allow the news to be "absorbed" and to avoid misperception or deceit.

The author stresses the similarities between prognosis and prophecy and the ethical foundations on which prognostication may be based. Issues regarding palliative care and end-of-life events, such as withdrawal or withholding of life support, hospice referral, and physician-assisted suicide, are especially relevant at this time.

The book is well written and covers many aspects of prognosis—historical, social, educational, scientific, and personal. Christakis covers the subjects thoroughly, using his own experiences as well as anecdotes. Research is thoroughly documented, with an extensive compilation of notes and references.

**E. W. Messey, MD**, is clinical assistant professor of family practice at UMDNJ and MCP Hahnemann.

## PEOPLE IN THE NEWS



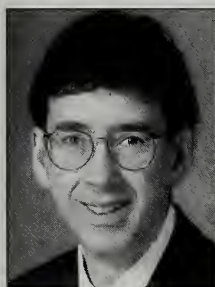
Gayle Holtzman, MD

**Gayle Holtzman, MD**, a hematologist and medical oncologist, has joined the medical staff at the Cancer Institute of New Jersey at Hamilton.



Fredric Seinfeld, MD

**Fredric Seinfeld, MD**, and **Glenn W. Laub, MD**, have joined the active medical staff at Robert Wood Johnson University Hospital at Hamilton in the department of surgery, section of thoracic/cardiovascular surgery.



Glenn W. Laub, MD

**Margaret C. Fisher, MD**, has been named chair of the department of

pediatrics and **Louise P. Hall, RN, BSN, MHA**, has been named director of surgical services at Monmouth Medical Center. **Marsha E. Rubin, DDS, FAOM, MAGD**, has been named residency program director of the department of dentistry at Monmouth. Joining the medical staff at Monmouth is internist **Gautam J. Desai, MD**.

**Elizabeth Candell Chalom, MD**, chief of pediatric rheumatology at Saint Barnabas Medical Center in Livingston, was elected to the board of directors of the Arthritis Foundation, New Jersey chapter.



Lawrence T. Taft, MD

**Lawrence T. Taft, MD**, has been awarded the Humanism in Medicine Award during a meeting with faculty at the Robert Wood Johnson Medical School of UMDNJ.



Mary Angarone

**Daniel Graziano**, chair of the Lakeview Child Center Board of Trustees at Robert Wood Johnson University Hospital, recently announced the appointment of **Mary Angarone** and **Salud Olessi Montano** as members.



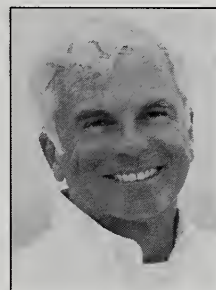
Salud Olessi Montano

**David Sirota, DO**, has been appointed president of medical affairs and director of

medical education at Union Hospital.

Monmouth University announced that it has selected **Dr. Marilyn M. Lauria** as dean of the Marjorie K. Unterberg School of Nursing and Health Studies.

The Auxiliary of Robert Wood Johnson University Hospital at Hamilton has announced that this year's recipient of its student scholarship is **Aakash Desai**, a graduate of Bordentown Regional High School who is attending Rutgers University (Livingston campus).



Robert G. Jarmon, MD

**Robert G. Jarmon, MD**, has been elected president of the Alumni Association of the UMDNJ-New Jersey Medical School.



E. Joseph Hummel, Jr

**E. Joseph Hummel, Jr**, senior vice president of health services and COO of Kennedy Health System, has been named to a three-year term on the board of directors of the American Red Cross/ Camden County Chapter.

Ladies Professional Golf Association member **Val Skinner** received the Robert Wood Johnson University Hospital Woman of Distinction award for her extraordinary work fighting breast cancer.

Spirit of Women, a corporate partnership sponsored by Ortho-Dermatological, Ortho-McNeil, and *Prevention* magazine, named Spirit of Women awards to youth recipient **Vanessa Ortiz**, community recipient **Irma Covarrubial Shaw**, and medical recipient **Dr. Patricia Whitley-Williams**, associate professor of pediatrics at UMDNJ-Robert Wood Johnson Medical School.

From the Commission on Cancer: three-year appointments as cancer liaison physicians for the hospital cancer program have been



given to **Hitendra Upadhyaya, MD**, at Jersey City Medical Center, and **James Dalzell, MD**, at Burdette Tomlin Memorial Hospital.

**Manuel Vergara, MD**, was recently recognized as a diplomate of the American Board of Electro-diagnostic Medicine. He sees patients at Lawrenceville Neurology Center and is on the staff at Capital Health System, Trenton.

Robert Wood Johnson University Hospital (RWJUH) announced that **Alfred C. Koeppe**, president and COO of Public Service Electric and Gas Company, will chair the fundraising campaign for the Bristol-Myers Squibb Children's Hospital at RWJUH, the first free-standing children's hospital in the state.

### INVESTIGATIONAL STUDY OF DIRECT MYOCARDIAL LASER REVASCULARIZATION

Mid-Atlantic Cardiology in Morristown is one of 21 locations around the country involved with an ongoing clinical study designed to establish the therapeutic value of direct myocardial laser revascularization in coronary heart disease patients. It is designed to improve angina symptoms in patients who are not candidates for surgical treatment or angioplasty. For more information, call (973) 884-8700.

### MEDICALERT LAUNCHES END-OF-LIFE NATIONAL REPOSITORY

MedicAlert Foundation, an emergency medical information service, has announced the launch of a

national repository for end-of-life medical preference documents, including directives concerning life support, resuscitation, organ donation, living wills, and power of attorney. The services include support from a 24-hour call center that is available 365 days per year, referral service for advance directives forms and assistance, verification of completed forms, physician and health-care agent notification on enrollment, family notification service, and safe storage and transmission of advance directives. For more information, call (888) 904-7630 or visit [www.medicalert.org](http://www.medicalert.org).

### TEACHING HOSPITALS PROVIDE BETTER CARE FOR OLDER HEART ATTACK PATIENTS

According to a study for the Agency for Healthcare Research and Quality (AHRQ), elderly patients treated for heart attack at teaching hospitals are more likely to survive and receive better-quality care than those treated at other hospitals. Most of the teaching hospital patients' lower heart attack death rates were due to having received better quality of care. Patients at teaching hospitals were more apt to be given aspirin during their stays, if appropriate, and more likely to be given beta-blockers and angiotensin-converting enzyme inhibitors upon discharge, when appropriate.

### CARDIAC REHAB PROGRAM RECEIVES NATIONAL CERTIFICATION

The New Jersey Heart Institute at Our Lady of Lourdes Medical

Center has been awarded program certification for its cardiac rehabilitation program by the American Association of Cardiovascular and Pulmonary Rehabilitation. The New Jersey Heart Institute at Lourdes offers advanced cardiac diagnostic testing, cardiac catheterization, angioplasty, electrophysiology, cardiac surgery, and rehabilitation and support services. For more information, call (856) 757-3970.

### ACADEMY OF MEDICINE OF NEW JERSEY HAS NEW LOCATION

The Academy of Medicine of New Jersey has moved to Lawrenceville, joining MSNJ and the MIIX Group of Companies in the same building. The address is 2 Princess Rd., Suite 101, Lawrenceville NJ 08648. For more information, e-mail [bartolo@acadmed.org](mailto:bartolo@acadmed.org).

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## CAREERS ON THE WEB

One of the most frequent questions fielded here is how to find out about employment opportunities for physicians in New Jersey, often asked by people currently residing in other states. Medical job sites are not as huge as general sites, but a few are worth looking into. The following were found through a search engine query for "medical careers."

The winner, far and away, was [www.medcareers.com](http://www.medcareers.com), with 81 physician positions in NJ and 7,300 physician jobs in all. In addition, there were many, many other health care-related jobs. The runner-up was [www.HealthcareMatch.com](http://www.HealthcareMatch.com), with five. Interesting sites that are worth a look (although they didn't list any NJ positions) are [www.jobscience.com](http://www.jobscience.com); [www.physicianexecutive.com](http://www.physicianexecutive.com), an executive search firm; and [www.thedrs.net/careers.htm](http://www.thedrs.net/careers.htm), currently under construction. Two surprises were general job search sites that popped up as a result of the query: [www.jobvertise.com](http://www.jobvertise.com) listed three physician jobs in NJ, and [www.hotjobs.com](http://www.hotjobs.com) listed two. In addition to these, nonphysician health care professionals might want to look at [www.medicats.com](http://www.medicats.com) and [www.jobscience.com](http://www.jobscience.com).

## NJ HOSPITAL ASSOCIATION OPENS DISTANCE-LEARNING WEB SITE

The New Jersey Hospital Association (NJHA) and its affiliate, the Health Research and Educational Trust (HRET) of New Jersey, have launched a new distance-learning Web site to help home care nurses and administrators negotiate complicated federal requirements for billing and data collection. The site, [www.MyHealthEd.com](http://www.MyHealthEd.com), has two courses for home care professionals, the *Home Health PPS Survival Guide* and the *OASIS Survival Guide*. The initial offerings were targeted for the home health community because several recent federal mandates made home health ready for educational opportunities. To access the courses, users sign on to [MyHealthEd.com](http://www.MyHealthEd.com) and register. Free 10-day trial periods give first-time users an introduction to the courses. Then a single license fee, \$150 per course for an individual and \$450 per course for groups of as many as five users, provides one year of unlimited access to the course. Group licensees can receive volume discounts for signing up additional users. The courses are broken into 12 modules, with follow-up exercises, glossaries, and added links. For more information, go

to the site, e-mail [info@myhealthed.com](mailto:info@myhealthed.com), or call (877) 367-6542.

## ONLINE CME

[MedicalComputingToday.com](http://MedicalComputingToday.com) has a lengthy list of online CME courses. This section of the Web site is maintained by Marjorie Lazoff, MD, a board-certified internist practicing emergency medicine in Philadelphia and the medical editor of the publication. Course information includes whom it is presented by, the accrediting institution, the release date, the type of course, a content description, who it is approved for, the hours, the fee, the URL, and the date that the site was last visited. Visit <http://www.medicalcomputingtoday.com/0listcme.html>.

CMESearch.com also lists online CME courses, but if you like to travel, the site offers a search by location, keyword, date and date range, and specialty. Visit them at [www.cmesearch.com](http://www.cmesearch.com).



**Advancing the Practice**



# CALENDAR

**E V E N T**

**D A T E**

**L O C A T I O N**

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|                                                                                                                         |                            |                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------------------------|
| <b>CME Update 2000</b>                                                                                                  | November 14                | NJ Hospital Association Conference Center<br>Princeton NJ, (609) 275-4000                |
| <b>Fourth Annual "Companions on the Journey" Conference Exploring Mental Health and the Mind-Body-Spirit Connection</b> | November 15                | New Jersey Hospital Association,<br>Princeton NJ, (609) 396-6590                         |
| <b>Measuring Health-Related Quality of Clinical Trials</b>                                                              | November 16-17             | New York NY, mbarberan@mapi.fr                                                           |
| <b>Gynecologic Pathology—Approaches to Common Problems with Emphasis on New Entities and Techniques</b>                 | November 17-18             | Baltimore MD, (410) 955-2959                                                             |
| <b>10th Annual Abdol H. Islami, MD, Memorial Symposium—"Recent Advances in Neurology and Neurosurgery"</b>              | November 18                | Saint Barnabas Medical Center,<br>Livingston NJ, (973) 322-5777                          |
| <b>Women's Health &amp; Counseling Center and the Resource Center for Women and Their Families Reigning Women Ball</b>  | November 18                | Merck & Co. World Headquarters,<br>Whitehouse Station NJ, (908) 526-2335                 |
| <b>Research on Research Integrity</b>                                                                                   | November 18-20             | Washington DC, <a href="http://ori.dhhs.gov/page1.htm">http://ori.dhhs.gov/page1.htm</a> |
| <b>Appendicitis: New Issues and Approaches to an Old Disease</b>                                                        | November 18                | UMDNJ-Medical School, Newark NJ,<br>bartolo@acadmed.org                                  |
| <b>MSNJ Board of Trustees Meeting</b>                                                                                   | November 19                | Lawrenceville NJ, (609) 896-1766                                                         |
| <b>Advances in the Diagnosis and Treatment of Osteoporosis</b>                                                          | November 21                | Ancora Psychiatric Hospital, Ancora NJ,<br>bartolo@acadmed.org                           |
| <b>Disability Case Management and A Multidisciplinary Approach to Return to Work For Patients with LBP</b>              | November 28-29             | NYU Hospital for Joint Diseases, New York, NY,<br>(800) 872-3105                         |
| <b>Focused Assessment of Counseling and Testing</b>                                                                     | November 29                | Health and Agricultural Building, Trenton NJ,<br>bartolo@acadmed.org                     |
| <b>Back Pain and Disability—Unraveling the Puzzle</b>                                                                   | November 30-<br>December 2 | New York Medical Centre, New York NY,<br>(800) 872-3105                                  |
| <b>Interpretation and Treatment of Cardiac Arrhythmias</b>                                                              | November 30-<br>December 2 | Philadelphia PA, (301) 897-2694                                                          |

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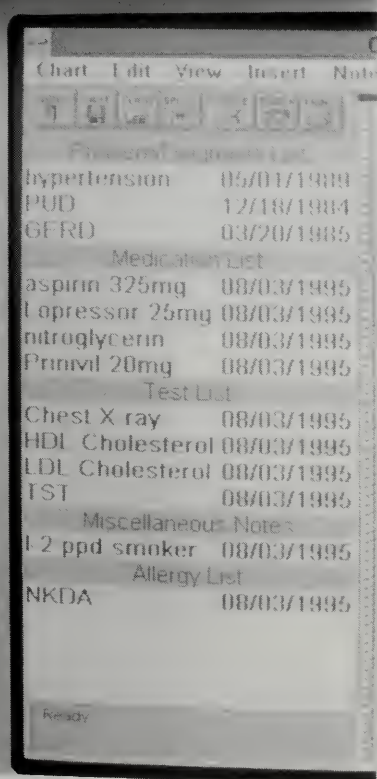
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| <b>Public Health: CARE Forums Institute<br/>Economic Forum</b>                               | December 6     | Lawrenceville NJ, (609) 896-1766                                    |
| <b>Oncology Society of NJ Tumor Board Meeting</b>                                            | December 6     | Hyatt Regency, New Brunswick NJ, bartolo@acadmed.org                |
| <b>Bioaerosols: Indoor Air Quality</b>                                                       | December 6     | Health and Agricultural Building, Trenton NJ, bartolo@acadmed.org   |
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| <b>Controversies in Obstetrics and Gynecology</b>                                            | December 6-9   | New York NY, (202) 863-2525                                         |
| <b>Council on Communications</b>                                                             | December 7     | Lawrenceville NJ, (609) 896-1766                                    |
| <b>Pathophysiology of Chronic Venous Insufficiency: Update on Mechanisms</b>                 | December 9     | UMDNJ-Medical School, Newark NJ, bartolo@acadmed.org                |
| <b>Fourth Annual Harvey Genetics Colloquium: Oversight and Regulation of Genetic Testing</b> | December 11    | GBMC Conference Center, Baltimore MD, (410) 828-3670                |
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| <b>Dermatology for the Nondermatologist</b>                                                  | December 15-17 | Grand Hyatt, New York NY, (800) 421-3756                            |
| <b>New York Cardiovascular Symposium</b>                                                     | December 15-17 | New York NY, (301) 897-2694                                         |
| <b>Specialty-Specific Outcomes Analysis and Pediatric Trauma</b>                             | December 16    | UMDNJ-Medical School, Newark NJ, bartolo@acadmed.org                |
| <b>17th Annual Clinical Update of Pulmonary Disease</b>                                      | December 17-20 | Sheraton Atlantic City, Atlantic City NJ, (609) 893-1200, ext. 5364 |
| <b>Lower Genital Tract</b>                                                                   | December 16    | Marriott Marquis, New York NY, (215) 542-3838                       |
| <b>MSNJ Board of Trustees Meeting</b>                                                        | December 17    | Lawrenceville NJ, (609) 896-1766                                    |
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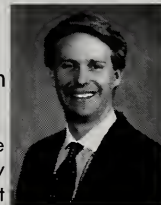
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1. Title of Publication: *NEW JERSEY MEDICINE*.
2. Publication No.: 0885842X.
3. Date of Filing: October 14, 2000.
4. Frequency of Issue: Monthly.
5. No. of Issues Published Annually: 12.
6. Annual Subscription Price: \$50.
7. Complete Mailing Address of Known Office of Publication: 2 Princess Road, Lawrenceville, Mercer County, NJ 08648.
8. Complete Mailing Address of the Headquarters of General Business Office of the Publisher: 2 Princess Road, Lawrenceville, Mercer County, NJ 08648.
9. Names and addresses of publisher, editor, and managing editor: Publisher: Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648. Editor: Paul J. Hirsch, MD, 2 Princess Road, Lawrenceville, NJ 08648. Managing Editor: Kim Kelly Horan, 2 Princess Road, Lawrenceville, NJ 08648.
10. Owner (if owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated): Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648.
11. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities: None (a nonprofit corporation of New Jersey).
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|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Extent and nature of circulation                                                                |                                                                         |                                                                                         |
| A. Total number of copies (net press run)                                                       | 9,671                                                                   | 8,877                                                                                   |
| B. Paid and/or requested circulation                                                            |                                                                         |                                                                                         |
| 1. Sales through dealers and carriers, street vendors, and counter sales (not mailed)           | —                                                                       | —                                                                                       |
| 2. Paid or requested mail subscriptions (include advertiser's proof copies and exchange copies) | 9,331                                                                   | 8,677                                                                                   |
| C. Total paid and/or requested circulation (sum of B1 and B2)                                   | 9,331                                                                   | 8,677                                                                                   |
| D. Free distribution by mail (samples, complimentary and other free)                            | 100                                                                     | 100                                                                                     |
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(signed) Joseph W. Cookson

## Health Insurance in the US

(from page 72)

model HMOs. Managed care has now become a system that many feel has been forced on the majority.

In my opinion, the shift from indemnity insurance to managed care was accomplished in large part by artificially deflated HMO premium rates charged to employers, resulting in unsustainable low premium charges. Simple economics dictates that because hospitals and physicians do not control premium costs, this practice was destined to result in unreasonably low reimbursement to providers. Today, premium costs are increasing as shareholders become more impatient for larger profits. Not only did the anticipated advantage of lower administrative costs under managed care fail to materialize, but costs escalated and bureaucracy increased.

Those of us who are involved in health care delivery are acutely aware of the high cost of health care. New technology and new treatments come with hefty price tags. Human nature and our basic sense of responsibility almost always dictate that when you or your loved ones need health care, you will seek out the best and the brightest, and yes, that often means the most expensive. Cost cutting has taken its toll, however, and because of layoffs and staffing shortages made necessary by inadequate reimbursement, we now face a dearth of nurses and most technical personnel. In addition, the nation is concentrating much of its attention on medical errors, a phenomenon no doubt brought about, at least in part, by cost cutting.

To many, the image of the health care system seems to have changed irrevocably, never to be viewed with confidence again. We cannot and should not simply stand on the sidelines and tolerate the inexcusable state of a health care system in which more than 40 million Americans (more than 18% of our population) do not have access to quality health care for

themselves or their families and in which those who are insured express ever-increasing frustration.

Health care should be viewed as a basic human right. Hospitals and physicians have the sobering responsibility of ensuring access to the latest, cutting-edge technology and advanced medical techniques to the patients we serve.

How do we guarantee every citizen's unquestionable right to these medical miracles? One thing is certain—whatever the model that is ultimately labeled as the answer, the demand for change is reverberating throughout our communities and our institutions. People are allowed freedom of choice in all other areas of their life and are demanding the same in health care. No doubt, in the years to come, we will see the "return of choice" integrated into the system. There are strong indicators that point to at least a partial return to a system of indemnity insurance with strong utilization review and the elimination of gatekeepers. Finally, as a nation that has always had a sense of social responsibility, we must find a way to ensure that all Americans have health insurance. While many disagree with a single-payor system, far fewer would disagree with universal coverage.

All of us must accept the responsibility for access as the number one problem in a society that wants free choice but wants to limit government intervention. An alternative to the current generation of managed care must be found. We must look to provide that safety net now, even if partnering with government appears to be the answer.

Could a solution ever be reached by a partnership that included insurance companies, physicians, health care administrators, employers, policy makers, and consumers?

*Harvey A. Holzberg is president and chief executive officer of the Robert Wood Johnson University Hospital in New Brunswick.*



# Health Insurance in the US

## Today and in the Future

Harvey A. Holzberg



Insurance, by definition, is "a means of guaranteeing protection or safety." At a time when we are witnessing some of the greatest advancements in discovering the causes of disease, when technology is reaching levels of intricacy never thought to be possible, when the

public is keenly aware of health issues and the concept of informed choices, and when we, as a country, take the global lead in defining new pharmaceutical approaches to manage disease, it remains an enigma to many that there are an ever-increasing number of individuals who are being branded with a word that has come to be received with embarrassing complacency: uninsured. The problems of the current health care environment, as we all know, are not limited to the uninsured but include patients with insurance who are still experiencing difficulties, as are providers and HMOs themselves.

And while the opinions on the reasons for this growing insurance problem range from one extreme to the other, no one would argue that there is a problem. The system is broken and needs to be fixed. I have no great revelations on how the system can be fixed, and I would in no way presume to offer a solution—simply observations and opinions.

Health care reform was created to address consumers' concerns about health care insurance, the cost of premiums, and what would happen if they or a loved one were stricken with a catastrophic illness. The goal of health care insurance for all Americans quickly became a major plat-

form issue in the political arena and a major crusade during the early 1990s. Today, in 2000, the platform still exists and everyone admits there is a problem, but agreement on how to solve it has been very elusive.

When we look at the issues that have had the greatest impact on the health care insurance system, it is apparent that the decline began when the HMO and managed care model became mainstream during the 1990s, well beyond anything ever envisioned by the earlier Kaiser Foundation model. Howard Veit, the former director of the Federal Office of Health Maintenance in the Carter Administration, recalled in a recent speech that before the rapid growth of HMOs began during the mid-1980s, many of the leaders of the major HMOs in the country, including James Vohs, the CEO of Kaiser Foundation Health Plan, warned that the worst thing that could happen to prepaid health plans would be for them to become mainstream. The leadership of health plans in those days wanted to remain an alternative to the traditional health insurance system. Many did not relish the thought of becoming mainstream because of the unrealistic public expectations that this would generate and the fact that managed care might be taken over by traditional insurers who did not share the same goals as the earlier prepaid group practices.

What Vohs was alluding to was that HMO enrollees during the 1970s tended to be individuals who were willing to restrict choice for lower cost and enjoyed the benefits of group practice; providers at HMOs were individuals who enjoyed the collegiality and lifestyle of staff and group

(to page 71)



# NEW JERSEY MEDICINE

HEALTH CARE IN THE GARDEN STATE

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## Good tidings, 21st-century style

In this era of pessimism and bad news for physicians, it's worth remembering that some problems do get resolved or at least reduced. Our most inveterate readers (how's that for a euphemism?) may recall that 25 years ago physicians faced a true crisis in malpractice insurance.

Late in 1975 the liability carrier preferred by New Jersey physicians was hiking premiums 50%. The Medical Society of New Jersey responded, created the Medical Inter-Insurance Exchange (MIIX), and brought rates under control through a physician-owned, physician-led, professionally managed enterprise that has grown to become an industry leader.

Can we respond equally effectively to today's challenges? MSNJ's current Board of Trustees and President Walter J. Kahn, MD, are aggressively pursuing agendas that are almost staggering in scope.

To regain market leverage for physicians and protect patients, MSNJ is lobbying for "joint nego-

tiation" legislation. A bill pending in the state senate would use the state action exemption of federal antitrust law to allow independently practicing physicians to negotiate together with large HMOs on a voluntary basis.

**On the HMO Front.** To upend HMOs' excessive administrative hassles and one-sided decisions, MSNJ is meeting with or confronting the state's largest HMOs—or both. (Your correspondent isn't going to refer to them by the more polite term "health plans" until they start addressing clinicians as "physicians" instead of "providers.")

So far, Aetna US Healthcare is showing flexibility on drug formulary issues, is communicating more openly with physicians, is paying claims on time routinely, is reevaluating its behavioral health program, has stopped retroactive fee reductions, and promises additional changes. UnitedHealthcare, the industry leader in hassle reduction, is moving most rapidly in New Jersey to free physicians from micromanagement.

Horizon BlueCross BlueShield has reorganized itself to improve claims management. The Physicians Health Service has replaced documentation review of evaluation and management claims with screening for outliers. Even CIGNA has fired the unpopular (yes, another euphemism) Magellan Specialty Health. And MSNJ helps its members with individual problems involving HMOs.

**I**s the profession of medicine becoming a less attractive career choice in the era of managed care? The Association of American Medical Colleges has announced a 3.6% drop in medical school applications for 2000-2001. But according to *Medicine & Health*, the AAMC says there still are two applicants for every slot.

**Broad Agenda.** To facilitate care of poor patients, MSNJ is advancing proposals to increase reimbursement under Medicaid and other state programs. To ensure physician leadership in quality of care, MSNJ has established the Medical Review and Accrediting Council. To unify the physician community, MSNJ and the Academy of Medicine of New Jersey have launched Physicians Conference 2000 and Physicians



Conference 2001, efforts unmatched in any other state.

To promote better health, MSNJ is the lead agency of both New Jersey's highly respected tobacco control coalition, New Jersey Breathes, and the state's public health coalition, CARE, which recently was accepted into the prestigious Turning Point program.

Other successful efforts—coordinated by physicians for physicians—include shepherding relief from losses caused by the HIP insolvency, generating improvements in end-of-life care, and making the profession of medicine a prominent political presence. MSNJ is also concluding an organizational development study to modernize the state-county medical society partnership.

## UNDER MANAGED CARE

Drug formularies may not be worth the annoyance, conclude researcher Susan D. Horn, PhD, of the Institute of Clinical Outcomes Research in Salt Lake City and colleagues. In a study published in the *American Journal of Managed Care*, Dr. Horn's team says that "greater limitation in the scope of available medications may result in higher drug utilization and higher office, emergency department, and hospital utiliza-

tion." The study of care given during 1992 to 13,000 patients in six HMOs in separate states covered arthritis, asthma, epigastric pain relief, hypertension, and otitis media.

Results were ambiguous for another managed care practice, the primary care gatekeeping system. Strict gatekeeping was associated with slightly higher numbers of office visits but lower utilization of emergency departments, hospitals, and medications. Perhaps follow-up research would show similar results for managed care during the late 1990s or early 2000s.

## COMMANDING THE TIDE TO TURN

"Defined contributions" may not be quite the wave of the future that many analysts have seen building on the horizon. Under this approach employees receive a fixed dollar amount of health care coverage and then must choose an insurance plan.

In an *Issue Brief*, the Center for Studying Health Systems Change notes that few employers are surfing this wave yet. Employers fear offending workers in a tight labor market by making an unpopular change in benefits. The standard, defined-benefits approach has advantages of full tax subsidies, risk

pooling, and bargaining clout. Defined contributions can cause problems in adverse selection as sicker or older employees gravitate to more expensive plans. And it's difficult to equip employees with information about different plans.

The center suggests that Internet-based approaches may energize the wave, though.

In another report, the center lists northern New Jersey as the only one of 12 areas covered by the Community Tracking Study where the percentage of children who are uninsured rose between 1996-97 and 1998-99. Still, only 8% were uninsured in 1998-99, compared with 11% across all sites.

## RETHINKING THE PROBLEM

The seriousness of today's nursing shortage is emphasized in a *Perspectives on the Marketplace* report. The major cause, of course, is wider career choices for women. Few policy makers are moving in the direction of an obvious answer—efforts to attract more men into nursing.

Men and women of good will face a turbulent future in health care. But there will be joy amid the suffering, good news as well as raunchy edicts, and seasonal hope, always hope.

Neil E. Weisfeld



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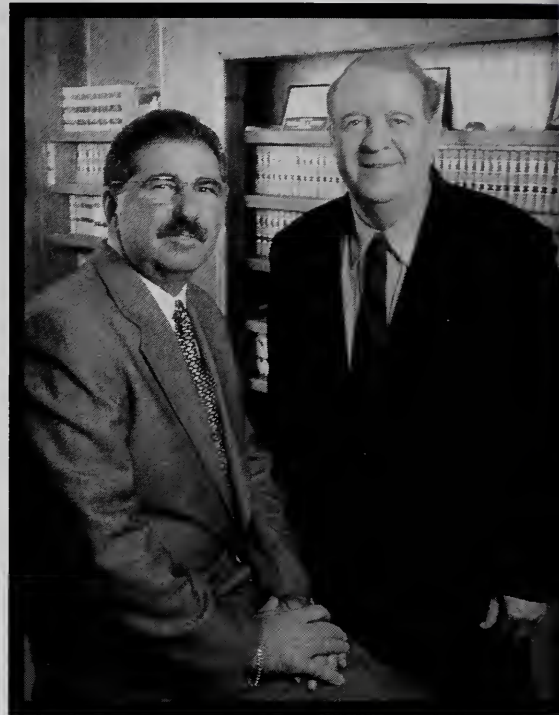
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## PERSONS OF THE YEAR 2000

The legislative process has become increasingly critical in determining the quality of health care and its mode of delivery. Decisions made by the state and federal legislatures in recent years may have had more impact on the health and medical care available to our patients than any university with fully funded grants.

We are therefore particularly fortunate in New Jersey to have responsible leadership in health care issues in both the Assembly and the state Senate. Recognizing this leadership and its value to the medical profession and the citizens of New Jersey, we have selected members of the Senate Health Committee as *New Jersey Medicine's* Persons of the Year. The

Republican committee chairman, Sen. Jack Sinagra, and the senior Democratic member of the committee, Sen. Richard J. Codey, have worked together to create and pass legislation that has been essentially nonpartisan and beneficial to New Jersey.

Senators Sinagra and Codey were selected as Persons of the Year 2000 for their strong positive impact on health and public policy, improving health care and health care delivery for the people of New Jersey during this year and in the past.

In our cover story in this issue, we review reasons for our selection and also recent and pending legislation.

## DR. ZISKIN APPOINTED

Leah Z. Ziskin, MD, has been appointed associate dean of the UMDNJ-School of Public Health, Stratford/Camden Campus. Dr. Ziskin is the former deputy commissioner of the New Jersey Department of Health and Senior Services and served the people of New Jersey and the medical profession with distinction in that office.

Dr. Ziskin has also been an associate editor of this journal for more than a year and has been instrumental in changing the character and improving the quality of the publication. Her knowledge of the discipline of public health, her prominence in the field, and the great respect

that she commands among professionals in the field have significantly enhanced our coverage of public health issues.

In all of her activities, Dr. Ziskin brings energy, an active and inquiring intellect, and the ability to involve others in her efforts. The School of Public Health is fortunate to have someone so dedicated both to her profession and to education to serve in this capacity. We are happy to report that despite her new and extensive responsibilities, Dr. Ziskin will continue her role on the editorial board of *New Jersey Medicine*, where she remains an invaluable asset.

**Paul J. Hirsch, MD**



## THE DOVER TOWNSHIP CLUSTER OF CHILDHOOD CANCER

Recent progress in the research of molecular biology and in the genetics of cancer, including the mapping of the human genome, has resulted in a greater understanding of the genesis of cancer and the role of the environment, possibly modified by host factors. It is clearer now that cancer results from a dynamic interplay of these factors, and this knowledge will surely assist us in the explanation of such complex matters as the phenomenon of cancer clusters and the steps that must be taken to identify and eliminate recognized environmental toxins.

In an interview in this issue, those investigating the Dover Township cluster of childhood cancer provide insight on how an increased incidence of cancer is investigated when it is allegedly associated with environmental hazards. Associations of this type are common, but it is rare to be able to confirm the relationship.

The methodologies of epidemiology and statistics, which are used to make the associations between bona fide cancer cluster cases and environmental hazards, depend on a large number of subjects. Without large numbers, differences between those affected and those not affected cannot be demonstrated to have occurred by means other than chance.

It is also difficult to determine which environmental factors to study. Furthermore, it is necessary to determine the means through which exposure occurs and to find the means to measure and quantify the exposure. Finding and matching controls can be especially difficult. In epidemiological studies, appropriate controls should be subjects of the same age, sex, and race who reside in the same geographic area. Once the controls are found, the questions that are asked must be directed to detect differences in exposure to the alleged hazard.

In the case of the Dover Township cancer cluster, there is indeed a higher-than-expected incidence of brain and central nervous system cancers among children in the Ocean County and Toms River areas. It was determined that envi-

ronmental contamination occurred in several locations, the result of apparent unauthorized deposition of industrial waste. The identification of purported environmental toxins has been more difficult. The role of a previously unidentified substance, styrene-acrylonitrile trimer, is unclear, since little or no information about that agent exists and its potential carcinogenic properties are unknown.

Factors including pregnancy; condition at birth; family history; health status; medication use; diet; and exposures to tobacco, alcohol, household products, animals, and electromagnetic fields have not been shown to yield differences between cases and controls. Yet to be analyzed are factors including the source and amounts of drinking water, residential proximity to identified hazardous sites, parental occupation, and purported exposure to sources of pollution. The New Jersey Department of Health and Senior Services (DHSS) anticipates that another report will be issued when these results are known. The DHSS, well aware of the pitfalls and limitations of studies of this kind, is very careful to make clear that expectations of a clear-cut association may not be possible, even in this instance of a demonstrated increased incidence of cancer and an identified environmental pollutant.

To assure the public and the health profession that progress in the investigation is being made, the DHSS issued an interim report in December 1999, disclosing its findings to date. The report is voluminous and attests to the comprehensive scope of the investigation. But it is incomplete, and further study of epidemiologic data—including parental occupation, environmental exposure assessments, the water supply, and possible exposure to sources of air pollution—must still be accomplished. A final report is not likely to appear before 2001.

**Leah Z. Ziskin, MD, MS**

### Women in Medicine Award

Thank you for the Palma E. Formica, MD, Women in Medicine award MSNJ gave me on October 7, 2000. I am very honored to be part of a group of remarkable women recognized in honor of a wonderful pioneer and leader for the cause of women's rights.

As a member of the Assembly Health Committee and of the New Jersey legislature, I look forward to continuing to work with MSNJ as we make progress toward ensuring that New Jersey women and all res-

idents receive the best health care available.

*Loretta Weinberg*

*Assemblywoman, Legislative District 37*

### Errors are inherent

We should applaud articles recognizing error as inherent in all human endeavors and the finding of mistakes beforehand as key to correction before mishap (President's Page, October 2000). I agree that in aviation, pilots know this instinctively, because their lives as well as the lives of their passengers hang in the same thin air—so

they look for the error and congratulate themselves when it is found and corrected before the plane leaves the ground.

Every health professional should know this too. If they don't, the medical examiners, lawyers, and our patients eventually find them out.

So if all our lives hang figuratively in the same thin air, it obligates every one of us to look for our mistakes and to fix them before takeoff.

*Morton H. Goldstein, MD*

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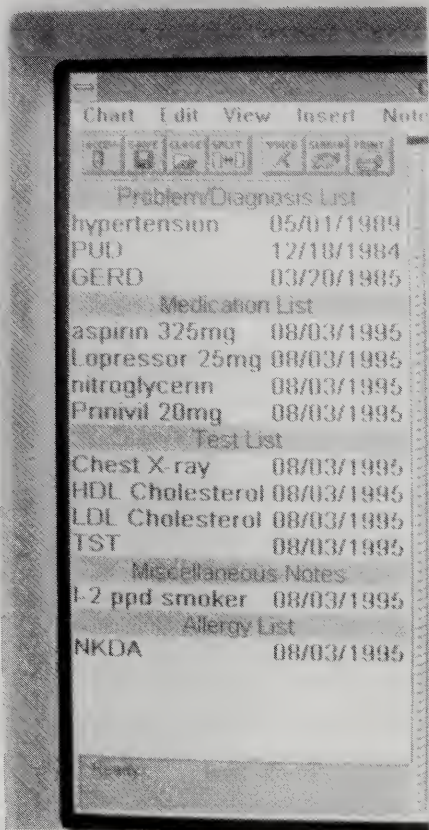
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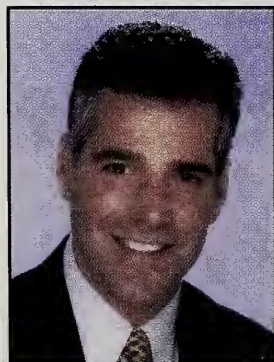
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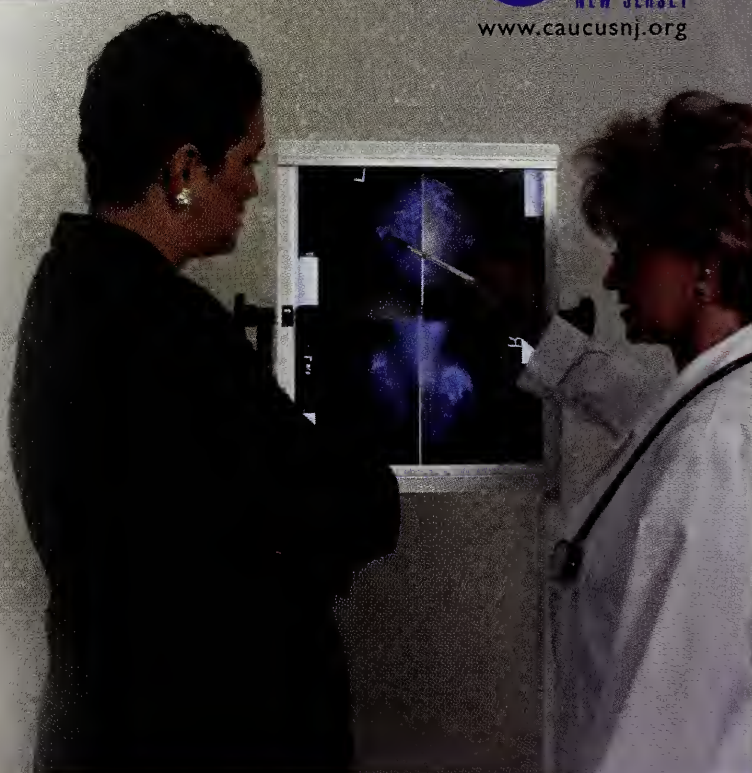
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# How Does Your Health Care Rate?

Walter J. Kahn, MD

As the year 2000 comes to a close, it seems appropriate to reflect on how we are doing with our health care, in particular with managed care, quality, and access.

Managed care (read managed cost) is excellent care if one manages not to get sick.

Once someone needs treatment, however, both patient and provider must stumble through a bureaucratic maze of delays and denials designed for one purpose—increased shareholder profitability.

Why is there a need for so many patient protection acts and prompt-pay laws throughout the country? Why are managed care companies exempt from medical decision liability? Why can't physicians collectively negotiate with insurers to fight for better care for their patients?

Managed care has become a disaster!

What about access? We hear a lot about our nation's 40-million-plus uninsured. How many of them, especially the low-risk younger population, are uninsured by choice? In effect, they have elected to become self-insured. How many others reside in America's large population of illegal aliens? And how many of these people eventually receive the medical care that they need, albeit free of cost?

Most of us would agree with the AMA that universal coverage with a choice of plans should remain our goal.

What about the quality of our care? There have been recent commentaries that the US ranks second from the

bottom among 13 industrialized countries. Japan and Canada rank in the top.

Too much care and a significant number of medical errors are listed among the reasons for our low ranking. Ironically, Japan rates high in comparison to us because of its *low* rates of treatment. Maybe we do have too much treatment available—but is that such a bad thing?

Our patients still have a choice—to increase their quality of life—an option that is not available in Canada or Japan.

The only exception to availability here are FDA-restricted drugs, devices, and procedures that are often unduly delayed for approval in the name of safety.

Do we see our citizens going to Canada or elsewhere for their medical care? Or do we see the reverse?

The US is still the mecca for health care excellence. Not only is treatment available, but it is of uniform quality throughout. Too bad our professional lives have been made so miserable by managed care.

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# *New Jersey Medicine* Persons of the Year

## Senator Jack Sinagra and Senator Richard J. Codey

SENATORS JACK SINAGRA AND RICHARD J. CODEY ARE NEW JERSEY MEDICINE'S PERSONS OF THE YEAR. THROUGH THEIR LEADERSHIP OF THE NEW JERSEY SENATE HEALTH COMMITTEE, THEY HAVE SHOWN A CONTINUING CONCERN FOR ISSUES THAT AFFECT THE HEALTH OF THE CITIZENS OF NEW JERSEY.



Every year, in our December issue, *New Jersey Medicine* recognizes a Person or Persons of the Year. In our selection process, we review accomplishments over a broad period of time, as well as activities and events that occurred during the past year.

Two New Jersey state senators, from different political parties, who have worked together on the vital health care issues in our state, have had a powerful and ongoing effect on legislative issues that involve medical care in New Jersey. Sen. Jack Sinagra, a Republican representing the 18th Legislative District, is the chairman of the Senate Health Committee. Sen. Richard J. Codey, a Democrat representing the 27th Legislative District, is the ranking minority member of the committee and the Democratic leader of the senate.

Senators Sinagra and Codey have shown a commitment to the solution of health care problems and have not allowed partisan differences to interfere with the consideration of these important issues.



It is particularly because of this bipartisan and cooperative approach to the critical issues that affect our patients and our profession that *New Jersey Medicine* is recognizing Sen. Sinagra and Sen. Codey as Persons of the Year 2000.

## SENATOR SINAGRA

Sen. Jack Sinagra was first elected to the New Jersey state senate in November 1991. In addition to chairing the Senate Health Committee, he is a member of the Task Force on the Affordability and Accessibility of Health Care in New Jersey. He has been a crusader against the tobacco industry and has helped to enact laws to increase the penalties for selling tobacco products to minors.

As committee chairman, Sen. Sinagra has been dedicated to improving public health and protecting patients' rights. He considers the enactment of the Health Care Quality Act of 1997, which provided new protections for managed care patients in New Jersey, to be one of his most significant achievements. His leadership in these areas was recognized by the American Medical Association, which awarded him its prestigious Dr. Nathan Davis Award in 1998. This award is given annually "to encourage and stimulate public recognition for the highest public service standards" and "underscore the significant accomplishments attained by men and women who are giving of themselves to advance the well-being of all." Only one state legislator in the country is selected each year.

## SENATOR CODEY

Sen. Richard J. Codey has been a member of the New Jersey legislature since 1974 and served four terms in the assembly before being elected to the senate, where he is now in his sixth term. He serves as the minority leader of the senate and is the ranking Democratic member of the Senate Health Committee. During his legislative career he has been especially interested in issues relating to health care

and gun control. He has been a strong defender of the 1990 Assault Weapons Ban.

Sen. Codey spent 10 years as chairman of what was then the Senate Institutions, Health, and Welfare Committee. He was instrumental in writing and passing the Health Care Cost Reduction Act of 1991 and cosponsored the New Jersey law requiring hospitals to allow new mothers to remain in the hospital for 48 hours after delivery. Because of his particular interest in mental health and reform of the state's mental health system, Sen. Codey has received the state Psychiatric Association's Citizen of the Year Award and the Mental Health Association's Service Award. Of particular note, he cosponsored the law that requires insurers to provide the same level of benefits for treating mental illness as they do for physical illness. He has also received the Academy of Medicine Citizen Award recognizing his contribution to health care in New Jersey.

## KEY LEGISLATION

Three pieces of legislation that passed the Senate Health Committee under the leadership of Senators Sinagra and Codey are particularly noteworthy: the Health Care Quality Act, the Prompt Pay Act, and the bill to provide reimbursement to physicians and hospitals for payments owed under the failure of HIP and the American Preferred Providers Plan (APPP).

The Health Care Quality Act ("Patient Protection Act") of 1997 regulated some aspects of the behavior of HMOs and the health insurance industry and enhanced patient rights. It improved the ability of patients to make treatment decisions and provided rights and mechanisms of appeal. This legislation banned the onerous and infamous gag clauses, which prevented physicians from fully discussing all alternatives of care with their patients. The law also required that the insurance company drug formularies be published and available and required that physicians who



are terminated from participation in programs be notified of the reasons and provided an opportunity to appeal.

Both Sen. Codey and Sen. Sinagra were major supporters of the prompt-pay legislation of 1999. It affects HMOs and all health insurers, requiring that clean claims be paid quickly and defining a clean claim. If the reporting is not "clean" or complete, it requires that the insurer notify the doctor of the missing elements of the claim in a timely fashion. The law requires that, as of December 28, 1999, electronic claims be paid within 30 days and paper claims within 40 days.

(To ascertain the effectiveness of this law, MSNJ has developed a prompt-pay survey. As outlined in a recent letter to members from MSNJ President Walter J. Kahn, the survey will track claims submitted during the week of January 15-20, 2001, and follow them through the processing period until payment. If any insurers are not in compliance with the law, MSNJ expects to have the data to prove it. To participate in the survey, look for the form in this issue.)

The New Jersey Insolvent Health Maintenance Organization Assistance Fund Act of 2000 provided compensation to doctors and hospitals for unpaid contractual obligations of HIP and APPP incurred before their insolvency. This provided an important element of confidence in the system to ensure continuing care for patients. In a report published in *New Jersey Medicine* last year, Sen. Sinagra expressed concern about the collapse of HIP and emphasized his determination to make the changes necessary to prevent the same problem in the future. He stated, "As terrible as the HIP insolvency was for the medical providers and patients involved, it has proven to be a long overdue impetus for change. The state has learned some hard lessons . . . and it is our duty as a legislature to under-

take the necessary reforms to ensure that such a woe-ful saga is never repeated."

*New Jersey Medicine* (represented by MSNJ Executive Director Vincent A. Maressa, MSNJ Legislative Representative Clark Martin, and *New Jersey Medicine* Editor Paul J. Hirsch, MD) recently discussed legislation and other issues in a conversation with Senators Sinagra and Codey.

## NONPARTISAN APPROACH OF COMMITTEE

**New Jersey Medicine:** Could you tell us how your committee seems to function so well in a nonpartisan fashion? Over the years, your committee, with the two of you involved, has approached health care as a topic, rather than as a political issue. There has virtually never been a party line vote in the committee.

**Sen. Sinagra:** Of all the issues that are on the front burner, health care has the least amount of politics involved in it. There truly is, for the most part, a right way to do things for the patients and the doctors and other providers and a wrong way. For the most part, politics doesn't enter into it.

**Sen. Codey:** I agree with that.

**Sen. Sinagra:** Our committee, of all the committees that I've ever sat on, is the best, as it pertains to the senators trying to work for a common good, health care. I cannot tell you how valuable I find it to have Sen. Codey, with all of his experience, give me advice and help guide the committee.

**Sen. Codey:** I really don't give him advice, but he is very fair. Most of the members are versed in the subject matter. Many have been on the committee for a while, and their experience has brought about an enlightened committee, whether or not you agree with them.

## STATE ACTION DOCTRINE COLLECTIVE NEGOTIATIONS

*Among the challenges that they are now facing will be legislative hearings for the state action doctrine, which would allow physicians to*

*collectively negotiate with HMOs and other insurers that control a 15% or greater share of their market. Senators Sinagra and Codey are supporting this concept, which would place physicians in a stronger position to negotiate for improved contract requirements, better utilization management rules, and better quality assurance, as well as for equitable and fair reimbursement. Similar legislation is currently in place in Texas.*

**NJM:** We appreciate the fact that you held public hearings in conjunction with the Physicians Conference in Atlantic City last May regarding the so-called state action doctrine, which is very important to our members. It would effectively allow physicians and hospitals to negotiate collectively with insurance carriers under certain circumstances and under specific guidelines. Insurance companies have been able to consolidate, whereas the doctors have not. We need to obtain some equity in the discussion. The key to the problem is that the markets, along with the state and federal governments, have allowed the insurers to consolidate to the point that they are absolutely dominant.

**Sen. Codey:** Of course, there have been many hospital consolidations in New Jersey. There are perhaps three major systems in New Jersey that may have close to 50% of the market, in terms of bed capacity.

**NJM:** But you could not say the same thing about physicians. Under the current antitrust laws, physicians cannot consolidate or combine in the same way. The state action doctrine would allow us to bring physicians together in larger groups so that they could negotiate together while maintaining their individual practices. We have suggested that it be done under the supervision of the state government, so that there is no question about getting out of line.

**Sen. Codey:** Wouldn't opponents of this say that by allowing this we would once again be driving up the cost of health care? That the end result will be to

increase fees, and then increased insurance premiums, and employers may not be able to offer insurance, and the average individual may not be able to afford it.

**Sen. Sinagra:** It is a difficult balance, and that is why we suggest state supervision for the process. Also, we do believe that as with auto insurance, health insurers should be obligated to justify rate increases. Now they merely have to file (but not justify) their rates. MSNJ has been meeting with the senate staff and representatives from the attorney general's office. They have been asking many questions and we are trying to answer them. We hope that it will be possible to craft amendments to answer the objections, so that we can move forward. Texas is the only state that has enacted similar legislation, but there has not yet been a negotiation under its provisions.

**Sen. Codey:** Hospitals have told me that they have signed contracts that are below cost, because a particular carrier covers such a large percentage of their patients. I assume doctors are doing the same.

**Sen. Sinagra:** We see the fights that are going on. Dominant carriers should not be able to force a hospital or physician to accept a fee that is clearly below the cost of delivering the service.

## PHYSICIAN PROFILING

*In an area in which many physicians may not agree with their efforts, Sen. Sinagra, Sen. Codey, and the health committee are developing legislation that would create a physician profiling system, which would give the public access to biographical and performance data for physicians practicing in New Jersey.*

*In an article for New Jersey Medicine in April 2000, Sen. Codey discussed legislation that would require the state to set up an electronic means for the public to access information about physicians. He referred to the Massachusetts system, noting that "consumers and others in Massachusetts can find . . . information about doctors, including a physician's education and training, awards and publica-*



tions, insurance plans accepted, and malpractice and disciplinary histories . . . . Visit this site [at [http://www.docboard.org/ma/ma\\_home.htm](http://www.docboard.org/ma/ma_home.htm)] and see what the future holds in store for us." He concluded by noting that the Massachusetts medical community supports the system and urges New Jersey physicians to do the same.

**Sen. Codey:** I am embarrassed that New York also has this in place and we do not. I know that you are opposed to it. We want to see something passed that is good for the consumer and yet fair to physicians. It is important that consumers have the information to make educated choices.

**Sen. Sinagra:** I am a cosponsor with Sen. Codey on this legislation, and I agree. Several other states have enacted similar legislation but have not yet implemented their programs. Essentially all states that do not yet have these programs are now considering them. Public access to this information is critical for patients to better select their physicians.

## CHARITY CARE

**NJM:** Payment for charity care continues to be a problem for New Jersey. Would you comment on payments under this program and the pressures that some hospitals feel?

**Sen. Codey:** Unfortunately, over the past eight or nine years, there has been an increasing financial drain on the hospitals, a drain on the entire system. As a result, there are fewer nurses and fewer employees to help deliver quality care, and the system is feeling the squeeze.

It is my opinion that virtually all of the fat that could be squeezed out of the health care system is basically out of it, and we may see significant increases in health insurance premiums over the next few years. I don't know yet what the answer will be.

**Sen. Sinagra:** I agree with that. I believe that there is a cost crisis. We have seen many different aspects of a health care crisis. A few years ago, it was an access

issue. Recently, we have dealt with managed care issues and dissatisfaction with the health care system. But it appears that cost will again come to the forefront as an issue and require decision making by us.

New Jersey is not afraid to be the first. New Jersey was the first state to propose an independent managed care appeals process, although we weren't the first to enact it. One of the things that I haven't talked to Sen. Codey about but that my staff has started to look at is requiring health insurance companies to justify their increases. We need to have some handle on what the companies are doing with their internal costs.

**Sen. Codey:** As mergers lead to fewer companies offering insurance, that may be necessary.

**NJM:** You have pointed out that the future appears to hold significant rate increases. If indeed, hospitals and doctors have been compelled to accept lower levels of reimbursement than 8 to 10 years ago, what is driving the upward spiral in costs?

**Sen. Codey:** We don't know. New technology may play a role, as may the need to solve the shortage of nurses. There are no easy answers any longer to reducing costs.

## HMO LIABILITY ACT

**NJM:** The HMO Liability Act has recently come out of committee. This bill would allow patients to sue their HMOs for acts or policies that could constitute malpractice. Do you believe that this legislation, if enacted, will have a beneficial effect?

**Sen. Sinagra:** Yes. New Jersey would be one of the few states across the nation that allow patients to sue their health insurance carriers for negligence with respect to the denial or delay of care that adversely affects the patient. I do not believe that it will have a dramatic effect, but it is important as part of a balancing act to make the HMOs more responsible for their decisions.

# The State of New Jersey is Serious about Health Care

*Senator Jack Sinagra and Senator Richard J. Codey*

On August 30 the Senate Health Committee unveiled a plan designed to cure what many New Jerseyans consider to be a languishing state health care system. Beginning in January Senate President Donald T. DiFrancesco and Senate Health Committee Chair Jack Sinagra set out to improve the system from the ground up, with the help of fellow legislators, professionals, and consumers. Together they took part in a six-month-long public hearing process. By gleaning information from the testimony of many individuals at all levels of the health care system, the Senate Health Committee was able to draft an innovative and comprehensive package of health care legislation. The objective was to create initiatives that would enable doctors and hospitals to work to their full potential while allowing patients to obtain and afford quality health care.

Among the initiatives designed to help health care providers ensure quality care is legislation that would provide \$55 million in additional Medicaid payments and charity care to those hospitals caring for uninsured and low-income patients. An additional \$2 million in state grant or loan money would be made available to hospitals for the purpose of modernizing their accounting systems so that service prices more closely reflect the actual cost of services to the institution. Another initiative that is aimed at keeping emergency rooms running smoothly and at lower costs is a bill that would make \$4 million available to hospitals for the implementation of low-overhead-cost facilities in nonacute emergency situations. These initiatives are only a few of the many bills in the Senate Health Committee's health care package that would help providers. For instance, one of the biggest burdens on physicians and their practices is the hassle of varying applications for participation in an insurance carrier's provider network. In response to this simple yet significant problem, the committee crafted a bill that would require health insurance carriers to use a standard application-for-participation form, thereby saving physicians and their staffs time that could, and should, be used to care for New Jersey patients.

It is concern for the patient's welfare, after all, that serves as the motivation behind so many of the initiatives in

this package of legislation. Undoubtedly, one of the most controversial initiatives in the proposed package is the right to sue, which would enable New Jersey patients to sue their health insurance carrier for malpractice in situations where the carrier's health care decision resulted in injury to the patient. This bill levels the playing field on which patients, HMOs, and insurance companies stand.

Among the other bills poised to regulate HMOs is an initiative that would allocate an additional \$1.3 million to the Departments of Health and Senior Services and Banking and Insurance for HMO oversight. The New Jersey State Legislature hopes to make it known that we are serious about the well-being of the system and people involved.

Our legislature is adamant about lowering the cost of health care so that all New Jersey patients can feel secure about their ability to afford health care. This legislative package includes an initiative to increase funds by \$1.5 million for the Office on Minority Health. It provides support to seniors who qualify for Medicaid and whose spouses are in a health care facility. Small businesses may opt for a regulated alternative to commercial insurance through the Small Employer Health Benefits Exchange, thereby saving money. This package encourages the modification of existing legislation by allowing the carriers to market health insurance on the Internet.

We are especially proud of the Senior Gold Prescription Discount Program, a landmark piece of legislation that would provide eligible middle-income seniors with prescription coverage.

The Senate Health Committee owes a great deal of gratitude to all those who participated in the public hearing process. Without the insight and support of those who testified on behalf of the New Jersey health care consumer, this package of legislation would not be complete. As a state, we should take pride and comfort in knowing that New Jersey takes health care seriously.

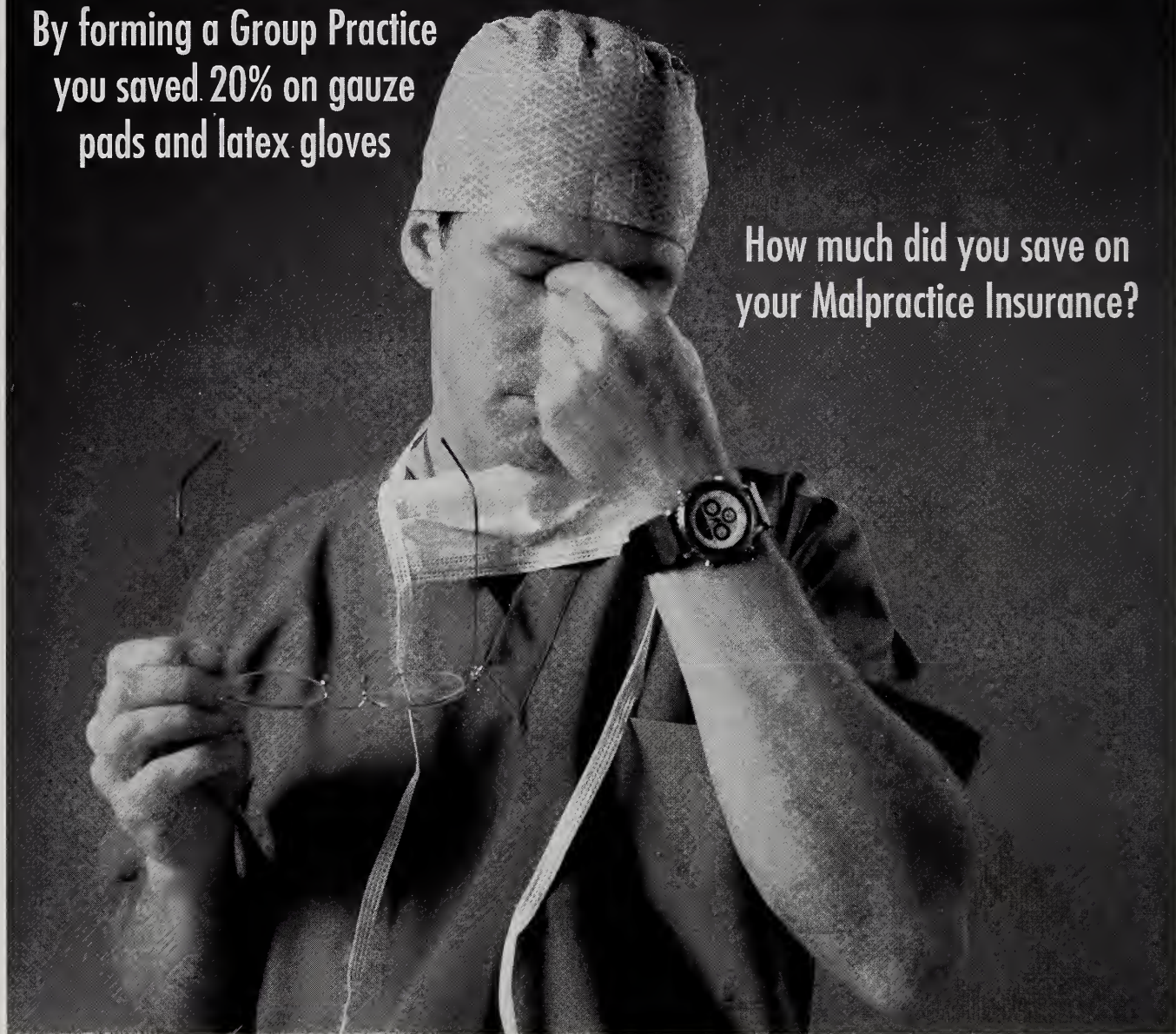
*Jack Sinagra is chair of the New Jersey Senate Health Committee and represents Legislative District 18. Richard J. Codey, senate minority leader, serves on the Senate Health Committee and represents Legislative District 27.*



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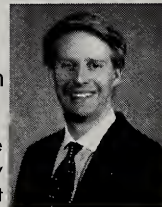
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# "Hanging Together"

## Physicians Conference 2001

### Builds on Success

It bears repeating: as Benjamin Franklin said to the Continental Congress at the signing of the Declaration of Independence, "We must all hang together, or assuredly we shall all hang separately."

In an effort to create an even greater collegial atmosphere among physicians throughout the state, MSNJ will present the second Physicians Conference from April 20-22, 2001. The Atlantic City Convention Center will once again play host to this comprehensive conference of our state medical society and the various specialty societies throughout New Jersey.

The success of the initial conference exemplifies our national leadership in physician and medical advocacy. In particular, the presence of the New Jersey Senate Health Committee hearing last year was of great benefit, as physicians promoted the state action doctrine directly to these elected officials. The legislation, which would allow physicians to negotiate with managed care companies, was placed before the full senate last month.

Many ideas and feedback generated from the last conference will be implemented to improve the next event. Working toward our first objective, we are excited to offer more than 50 clinical, practice management, and general workshops covering an array of topics on today's pressing medical issues. These educational tools will enable us to improve our comprehensive health care services provided to patients and to make our practices more efficient.

The conference's second objective is to unify the physician-political environment. New Jersey physicians must speak with one voice to serve our professional interests and those of our patients when legislation or regulation is crafted in Trenton. No longer can we allow contradictory forces to subdue our message.

Our third objective is to allow the physicians within the state to get to know one another. The social opportunities at these events will allow physicians from diverse fields to network and relate to one another's concerns.

Some highlights at Physicians Conference 2000 were the well-received keynote addresses by nationally recognized speakers. This year, we are excited to have Beck Weathers, MD, as a keynote speaker. Dr. Weathers survived one of the deadliest expeditions in history to the summit of Mount Everest, which was the subject of the bestseller *Into Thin Air*. He will tell the terrifying and triumphant accounts of these brave individuals who ventured to the top of the world—an experience that has captivated audiences the world over.

Building on last year's success, we expect the next conference to be bigger, better, and more fruitful for our physician community. Registration forms will be coming soon in the mail and in future issues of *New Jersey Medicine*. You will be able to register shortly on our Web site at [www.msnj.org](http://www.msnj.org).

I look forward to seeing you in Atlantic City.

**Joseph Reichman, MD**  
Chairman, Physicians  
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# The Dover Township Childhood Cancer Investigation

AN INTERVIEW WITH JAMES BLUMENSTOCK, MA, SENIOR ASSISTANT COMMISSIONER; JERALD FAGLIANO, PhD, PROGRAM MANAGER; AND EDDY BRESNITZ, MD, ASSISTANT COMMISSIONER/STATE EPIDEMIOLOGIST AT THE NJ DEPARTMENT OF HEALTH AND SENIOR SERVICES.

In 1995 the New Jersey Department of Health and Senior Services (DHSS) determined that the incidence of childhood cancer—specifically, brain and central nervous system cancer in children under the age of five—in a New Jersey community was significantly higher than expected. This finding, which confirmed public perceptions, as well as the location within the community of two Superfund sites generated a comprehensive undertaking by state and federal agencies to account for the observation and to determine possible etiologies.

Beginning in 1997 the DHSS designed and conducted an epidemiologic study primarily for the purpose of identifying possible disease risk factors that might have led to the increased cancer incidence. In December 1999 the agency released an interim report of its findings. Although the interim report did not identify

significant differences in potential exposures between cancer cases and appropriately chosen control groups, the DHSS cautions that the study remains incomplete and no conclusions should be drawn at this time. Other factors, including the source of the drinking water, residential proximity to hazardous sites, parental occupation, and purported exposure to sources of air pollution remain to be analyzed. The final report is due by the end of 2001.

New Jersey Medicine associate editors Leah Ziskin, MD, and Alan Lippman, MD, met with James Blumenstock, MA, senior assistant commissioner; Jerald Fagliano, PhD, program manager; and Eddy Bresnitz, MD, assistant commissioner and state epidemiologist at DHSS. The following interview seeks to understand the motivation behind this comprehensive study and the methodologies that are used to evaluate a cancer cluster.

**NJM:** How and when was the cluster of childhood cancer in Dover Township identified?

**Dr. Fagliano:** The Toms River community had been concerned about the number of cases of childhood cancer since the early 1980s. In 1995 there were also reports from the Children's Hospital of Philadelphia (CHOP) that there appeared to be an unusually high number of referrals made to the oncology department from Dover Township NJ. The reports from CHOP went to the office of the Environmental Protection Agency (EPA) serving the Philadelphia region. Through a series of referrals, the reports reached the New York regional office of the federal



Agency for Toxic Substances and Disease Registry (ATSDR), which covers New Jersey. These reports prompted the federal agencies to request the state to look into the matter.

There was insufficient data to confirm the community's concerns until 1995, when the DHSS determined that children under 20 years of age in Ocean County had higher rates of brain and central nervous system cancers than other children in New Jersey for the period of January 1979 through December 1991. Children under the age of five years in both Ocean County and the Toms River area of Dover Township also had higher rates of these cancers compared with children of the same age throughout the state.

**NJM:** How were these findings made public?

**Dr. Fagliano:** On March 21, 1996, then-Commissioner of Health Len Fishman convened a public meeting and initiated a thorough investigation into the epidemiology of the cancers and the environmental conditions that the community perceived were the cause. The federal ATSDR and EPA regional offices and the local and state health and environmental agencies would work cooperatively to study the problems. The residents formed the Citizens Action Committee on Childhood Cancer

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Cluster, which would act as a liaison between government agencies and the community. By June 1996 the follow-up to this meeting was the development of a public health response plan. The elements of the plan were to:

- Describe the environmental quality of the community, which included an assessment of the Superfund sites in the community, testing of the public drinking water supply, and a search for other environmental hazards.
- Reanalyze the cancer statistics to validate and enhance the results of the 1995 cancer evaluation, determine the frequency of cancer types, and develop follow-up strategies.

When Superfund sites are assessed, it means determining whether there could be exposures in the commun-

ity from chemicals or other materials contained at the site. There were two previously identified Superfund sites (the Ciba-Geigy chemical manufacturing plant and Reich farm) in the Dover Township community. These were assessed as well as the Dover Township municipal landfill.

As these studies progressed, we committed to a case-control epidemiologic study of the childhood cancer cases.

**NJM:** How did the community react?

**Mr. Blumenstock:** The community has been very involved since the onset of the investigation, and this involvement has helped the study in several ways. The community was able to engage and keep the political decision makers interested in the outcome of the study. Without this support, a study of this type could not be financed. The resources of the federal and state government were essential to carry out the tests, surveys, and other analyses.

**NJM:** What role did the media play?

**Mr. Blumenstock:** Overall, the quality of the media coverage was generally good. It was a fair and objective presentation of the facts. However, I noted that the local press did a better job than the national press of accurately portraying all points of view.

**NJM:** Can you tell us what studies were carried out and the results?

**Dr. Fagliano:** We tested numerous points within the community water distribution system, and we also tested every well and every well field that supplied water to the water system. One of the findings was an unidentifiable material that was associated with one particular well field. This unknown material didn't match up with anything that anybody had ever seen before. It took laboratory detective work by scientists from the NJ Department of Environmental Protection (DEP) and DHSS, as well as scientists in the EPA laboratories, to identify the material, which was named styrene-acrylonitrile trimer (trimer). This substance had never been seen in any drinking water supply anywhere before. It was a by-product of a plastics manufacturing process that was done by Union Carbide during the 1960s and early 1970s in Bound Brook.

We knew that the Reich farm hazardous waste site, a designated Superfund site, had been contaminated with about 5,000 drums of waste material from the Union Carbide Bound Brook plant. Union Carbide was in the midst of an extensive cleanup with the US EPA of this particular site. Because of this link, we were able to define that this water supply, in 1996, had elements of the waste stream in it from the Union Carbide plant. Although the EPA, the local water company, and

the DEP had a treatment system in place on the wells in this well field, they didn't know of the presence of this formerly unidentified material, and so the treatment system was not designed to remove it. This leads us to believe that for some unknown time, until 1996, this material was in the drinking water, at low levels of contamination. We still cannot say that the presence of this material has anything to do with the increased incidence of childhood cancer. However, this is one of the issues being examined in the current epidemiologic study.

**NJM:** What is the status of the Ciba-Geigy plant, the Reich farm, and the Dover Township municipal landfill assessments?

**Dr. Fagliano:** The Ciba-Geigy plant was a chemical manufacturing facility located in Dover Township that operated from 1952 through 1996. It is now closed. Currently it is undergoing an environmental cleanup of contaminated groundwater treatment beneath the site, and plans are under way for treatment of the contaminated soils on the site.

**This substance had never been seen in any drinking water supply anywhere before.**

The Reich farm was a privately owned chicken farm. In 1971 the owners leased a portion of their farm to a waste hauler for the supposed purpose of staging clean drums. The waste hauler, in violation of the agreement, ended up using a portion of the farm as a waste dumping site, and about 5,000 drums of chemical waste were taken to the site and either emptied or deposited. The soil in that area is very porous, sandy, like most of the Jersey shore. Some of these drums of industrial wastes ended up at the Dover Township municipal landfill, another area of concern.

One of the reasons we decided to check the municipal landfill was because the waste that came from Union Carbide and went to the Reich farm also was disposed of in this landfill. Recent investigations by the township have shown that trimer is also a contaminant in the groundwater beneath part of the landfill.

In 1971, at the time of the dumping at the Reich farm, the Toms River Water Company, the major groundwater supplier to the area, began developing an expansion of its system, which was called the Parkway Well Field. The new wells were about a mile south of the dumping site. Given the porous nature of the soil and the way that major well fields tend to draw water toward them, it



was an unfortunate colocation of these two entities.

**NJM:** Once the scientists have identified a contaminant such as trimer, how is it determined whether or not the contaminant is inert or an environmental hazard?

**Mr. Blumenstock:** Here we have a contaminant that is unique to Dover Township. We know very little about it. However, some of the parent chemicals that make it up have a toxicological history. A decision needed to be made as to whether the public should continue to be exposed to it or whether we should take prudent measures to interrupt exposure until we learn more. Exposure could be and was interrupted on discovery in this case. Because we knew very little about this chemical from its toxicological properties, the US EPA, working with the responsible party, Union Carbide Corporation, committed to perform a series of short- and long-term acute toxicity and carcinogenesis studies. But whether or not consuming water that contained this contaminant is a risk factor for childhood disease is one of the many elements that were included and will be examined in the case-control study.

**NJM:** Will you explain what you are seeking by using a case-control study?

**Dr. Fagliano:** We use a case-control study to determine what dif-

**Recent investigations by the township have shown that trimer is also a contaminant in the groundwater beneath part of the landfill.**

ferences occurred in past exposures between children who developed cancer and those who did not. If we find differences that are unlikely to have occurred by chance or that are statistically significant, then we have leads into associations that are suspect but not proven causes of disease. Statistical studies have more validity if large numbers are available to make comparisons of differences. This gives studies more power. In studying the cancers in Dover Township, we are dealing with an investigation of incidence in one community. This means we are inherently limited by the numbers of cancers that have occurred there, and our study is limited from a statistical perspective with limited power to detect associations, because the numbers of cases and controls are small.

What we found after we analyzed the updated case reports from 1979

through 1995 was that in Dover Township overall cancer incidence was elevated statistically. What seemed to be driving that, in particular, was an increase in leukemia among females; and that increase seemed to be most extreme in female children under the age of five. When we looked at the Toms River section of town, we saw a similar kind of pattern. In that area not only leukemia but also brain and central nervous system cancers were elevated.

The interview study cases are all children who were diagnosed from 1979 through 1996 with leukemia, brain/central nervous system cancer, or sympathetic nervous system cancer. The controls are selected from public school records. We identified four children per case, as controls, matched on residence in Dover Township at the time that the case was diagnosed and matched on sex and age. We were fortunate that the Toms River school district maintained records of children through the time period of the study. We had an 80% participation rate of the controls, which gives us a level of comfort.

**NJM:** Although the focus of your study is on environmental influences, have you considered the genetic predisposition factors that may be indicators of cancer? For example, it is known that Down's syndrome, of genetic etiology, is

associated with an increased incidence of leukemia.

**Dr. Fagliano:** We have asked a few questions regarding history of cancer in parents, grandparents, and siblings of the study subjects. In addition, we have asked about the occurrence of diseases in the study subjects and their siblings.

Among our study subjects, we do not have any individuals with Down's syndrome.

There are 40 cases and 159 controls in the interview case-control study. Of the cases, 22 had childhood leukemia and the remainder had cancers of the nervous system. This is a relatively small study, and with these small numbers it is not likely or possible to make the associations about genetic factors or gene-environment interactions that a large-scale national or international study would reveal.

**NJM:** This brings up the concept that cluster investigation, as a rule, has not been shown to be one of the successful ways of finding causes of cancer. Is there a change in thinking among epidemiologists on the value of investigating clusters of disease?

**Dr. Fagliano:** No, there's been no change in the general approach to the investigation of clusters. The general approach, as recommended by the Centers for Disease Control and Prevention (CDC), is to have a tiered system of response to report-

ed clusters of disease. Initially, the concerns are screened and a large-scale investigation proceeds only if the increase in incidence is validated and if there is reason to believe that there are factors that can be investigated. Many alleged cancer clusters come to the DHSS's attention. However, the vast majority of clusters are screened out because either one or both conditions are not met.

The Dover Township cluster is an unusual investigation for the DHSS, because we usually do not get to the point where a full-scale study is launched. In the case of the Dover Township cancer cluster, these two conditions were met and the DHSS proceeded.

In occupational settings, there have been successful linkages between certain specific illnesses

with high exposures to chemicals or unsafe practices. In a community setting, such linkages are rare, because we usually see much lower levels of exposure and multiple exposure factors compared with an occupational setting.

**NJM:** Can you summarize the status of your investigation and when you expect to release a report on the findings of the epidemiologic case control study?

**Dr. Fagliano:** We have completed all the environmental assessments and environmental investigations in the community, and we have identified those factors that we believe need investigation in the epidemiologic study. Data collection for the epidemiologic study was completed early in 1999, and we have conducted analyses of some risk factors included in the questionnaire.

We are following up on the much more complex environmental exposure assessments for the study subjects in the case-control study. We are focusing on access to different water sources in the community and whether exposure occurred as a result of different well fields within the public drinking water supply or to private wells. This is being accomplished through very complex water distribution system computer modeling being performed by ATSDR. We're looking at the potential for exposure to sources of air

**The interview study cases are all children who were diagnosed from 1979 through 1996 with leukemia, brain/central nervous system cancer, or sympathetic nervous system cancer.**



pollution within the community, one being the Ciba-Geigy plant. We're also looking at the Oyster Creek generating station, which is located about 10 miles south of the community. In addition, we're examining parental occupational exposures to chemicals and radiological hazards. These assessments involve the development of complete computer models of the environment to reconstruct possible past exposure levels.

We hope to complete the report and have it peer reviewed and prepared for community release by the end of 2001.

**NJM:** How much did this study cost?

**Mr. Blumenstock:** This has been extremely expensive because of the environmental testing and the labor-intensive nature of the interview study. We estimate that more than 75,000 labor-hours from DHSS and DEP alone have been expended and with a total investigation cost that will approach \$10 million. This investment clearly illustrates the commitment of Governor Christine Whitman, the state legislature, and New Jersey's congressional delegation to gain a greater understanding of the possible explanation for the elevation of childhood cancers.

**NJM:** What has been the response from the local medical community?

## **The Dover Township cluster is an unusual investigation for the DHSS, because we usually do not get to the point where a full-scale study is launched.**

**Dr. Bresnitz:** The Citizens' Action Committee that represents the community has two locally practicing physicians as members. Over the past four years the DHSS has issued several health care provider updates to keep the medical community well informed. We have also done in-service training for school nurses about the environment and health in general, because they deal with children and their parents and are likely to hear their concerns.

One medically related issue that has come from the lay public is the perception of not having enough pediatric oncologists in the community. Parents of children with cancer in this community have generally taken them to Philadelphia for cancer treatment. Another medical issue that has been raised at a public meeting was from a mother who asked how we educate our doctors about making a diagnosis of cancer

in a child. Her concern was whether an earlier diagnosis would have led to earlier treatment and a better outcome.

**NJM:** Do you have any closing messages for our readers?

**Mr. Blumenstock:** Cancer is a major concern, and there is a high level of concern about environmental exposures causing cancer. We are asked repeatedly to link "cancer clusters," or increased incidence of cancer in a community to an environmental source. We try to explain to people, including our elected representatives, that it is very difficult to do. We have a gold standard cancer registry that is current with reported cancer cases in the state and sometimes even document environmental exposures. People think we should be able to link them, but in fact we often can't, for a variety of reasons, such as small sample size and inadequate history of exposures. We need to set clear expectations so that the public understands what we can and cannot do.

**NJM:** Thank you very much for providing us with this information about the Dover Township childhood cancer investigation and how the DHSS approaches the investigation of cancer clusters. We look forward to reading the final report. ■

*Additional information about cancer resources and the Dover Township childhood cancer investigation can be found on DHSS's Web site at [www.state.nj.us/health](http://www.state.nj.us/health).*

# It's Not Your Grandparents' Public Health

*Kristine M. Gebbie, DrPH, RN*

What images of public health have you accumulated over the years? Irritating paperwork when you have to report diseases, births, and deaths? A school nurse looking for the cause of an itchy scalp? A favorite restaurant closed because the refrigerator is nonfunctional? Crying children at an immunization clinic? A disease investigator seeking a reported TB contact? An inner-city clinic offering last-resort primary care? Reproductive health classes for adolescents? A laboratory alternating between high-tech DNA fingerprinting and the simplest tests of drinking water to detect sewage contamination?

A few years ago polling verified what many in public health practice have known for years: people really don't know what it is, but when they stop and think about it, they want it for their community.<sup>1</sup> That is, when asked, most respondents, if they could define public health at all, understood it to be medical care services for those who have nowhere else to go. On the other hand, when presented with a list of services gen-

erally provided by public health organizations, such as drinking water and food protection, immunization, and surveillance for infectious diseases, most people indicated these were desirable and supportable services. The public health community, both academics and practitioners, have taken a good deal of time during the past decade trying to understand this gap in understanding and identifying ways of communicating more effectively.

The lack of understanding of public health has not been limited to the general public.<sup>2, 3</sup> A substantial proportion of practicing physicians, nurses, and other health professionals have had little or no exposure to the field of population-focused practice or public health. Perhaps the fact that it is fundamentally interdisciplinary makes it easier to let it slip from the curricular radar screen; certainly the growth of content in what are seen as core practice areas has made it harder to preserve time for population-focused training experiences. These should not be confused with community-based education: many schools of medicine and nursing

take students out of the hospital and place them in offices and clinics for substantial portions of time, an excellent learning opportunity. But practicing individual care, whether in the home, the office, the clinic, or the hospital, is not the same as practicing public health, in which the community is the real client or "patient."

Fortunately, there is also a growing interest in the health of populations and in collaborations across traditional lines to improve the public's health. The American Medical Association, the American Public Health Association, and others have formed a collaboration intended to heal a breach in communication that goes back to the turn of the 20th century in this country.<sup>4</sup> Many of the community-based projects supported by the Robert Wood Johnson and W. K. Kellogg foundations in recent years have encouraged this effort. And the public health community has worked to provide clearer descriptions of what it does and how it can work effectively only in partnership with other health institutions and pro-



fessions, along with the communities served.

The statement *Public Health in America*, written in 1994 by 14 national organizations and federal agencies, provides the framework for today's thinking about public health.<sup>5</sup> Any of the images that began this article could fit in the framework, but it suggests pulling back from any one current programmatic effort to consider the ongoing purpose of public health. The specific programs, activities, and priorities at state and local levels will change over time, as health status, threats to health, and resources change. In moving to ensure that physical and mental health is promoted and disease, injury, and disability prevented, the public health effort must prevent epidemics, protect against environmental hazards, prevent injury, promote and encourage healthy behavior, respond to disaster and assist in recovery, and ensure the quality and accessibility of health services.

In addition to the development of new descriptions of public health itself, the dialogue has been advanced by the work of the Institute of Medicine's description of the process a community might undergo in seeking to improve its health status.<sup>6</sup> This process is interactive and iterative and is clearly something that no government agency, hospital, or community service group could do alone. Furthermore, this work helps clarify the fact that the exact range of services (and relationships among them) in any one com-

munity will change over time. In fact, in many states, the public health system established by laws a century or more ago is not in step with what is needed today. The level of specialization and technical expertise needed for effective public health practice is much more sophisticated today than it was even 25 years ago. The average community cannot afford, and probably does not need, a full-time complement of environmental and laboratory specialists, communication experts, or statisticians. However, every community should know that this full range of expertise is readily available and should have a local public health presence that facilitates a prompt response when it is needed.

The newly published *Healthy People 2010* has furthered our collective efforts to understand and promote public health by adding a section of objectives aimed at strengthening the nation's public health infrastructure.<sup>7</sup> This series of 17 objectives, if met, would ensure that every community is served by a computer-literate and electronically linked public health system that is staffed by individuals competent to deliver essential public health services within a modern legal framework. A wide variety of approaches can enable us to meet this plan. Finding the right approach for each community will take the active participation of many individuals. The medical community is a critical part of the framework within which public health operates. One measure of the

success of the medicine-public health initiative and improved communication about public health will be the role that the medical community of each state plays in fostering a healthy new public health for this new century.

Kristine M. Gebbie is director at the Center for Health Policy, Columbia University School of Nursing, New York NY.

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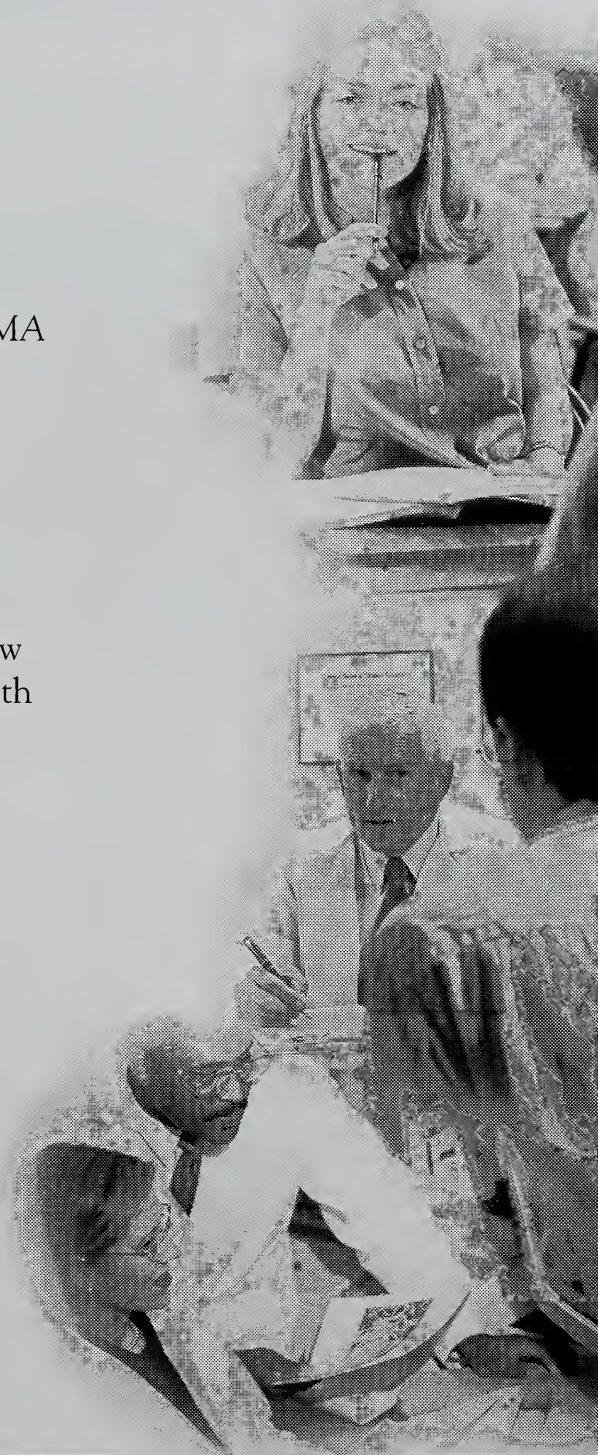
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# The Anesthesiology Claim Experience

## A Success Story

Theresa V. Arnold, DPM

Anesthesiologists have traditionally experienced higher exposures to malpractice litigation than have other medical specialists. However, the most recent data from the American Society of Anesthesiology (ASA) Committee on Professional Liability's Claims Project and MIIX claim experience demonstrates that severe anesthesia-related injuries are becoming less frequent and payments less prevalent, resulting in overall malpractice premium reductions (see Figure 1).<sup>1</sup> The rate at the \$1 million per case/\$3 million level per year decreased 44.1% since 1990.

Although respiratory-related events have commonly been the primary source of litigation, there has been a significant downward trend in the number of claims for death and brain damage caused by respiratory-related events since the 1970s (see Figure 2).

What accounts for these favorable trends? A major impact on the improvement in anesthesia patient safety seems to be from the use of intra- and postoperative pulse oximetry ( $\text{SpO}_2$ ) and end-tidal  $\text{CO}_2$  ( $\text{ETCO}_2$ ) for the verification of endotracheal intubation. These two monitors were introduced during the mid-to-late 1980s and became ASA standards of practice during the early 1990s.

Use or better use of one or both of these monitors has shown marked reduction in claims for injuries due to inadequate ventilation and esophageal intubation during the 1990s. Among these events, the most dramatic change occurred in the category of inadequate ventilation, which

accounted for 22% of all claims for death or brain damage during the 1970s but only 7% of claims during the 1990s. A similar but smaller change occurred with esophageal intubation, which accounted for 10% of all claims for death or brain damage during the 1970s compared with 7% in the 1990s (see Figure 3).

As the data from the 1990s accumulates, it is encouraging to see a continuing reduction in claims for death or brain damage and an improvement in the liability profile. Cardiovascular mechanisms of injury are becoming more prominent as respiratory system mechanisms are decreasing. This may reflect the fact that sophisticated monitoring allows a more accurate diagnosis of the exact mechanism of injury.

### WHAT'S ON THE HORIZON?

**Peripheral Nerve Injury.** As the frequency of claims for death and brain damage have declined, peripheral nerve injury has remained relatively constant over the years and may eventually emerge as the leading source of claims against anesthesiologists. Currently, peripheral nerve injury is the second most common injury, accounting for 16% of all claims. Most recently, an analysis of claims for peripheral nerve injury was published in *Anesthesiology*.<sup>2</sup> This study supports the evidence that most injuries to the ulnar nerve and brachial plexus occur under conditions of conventional positioning and padding. Unfortunately, effective preventive strategies cannot be developed until the basic mech-



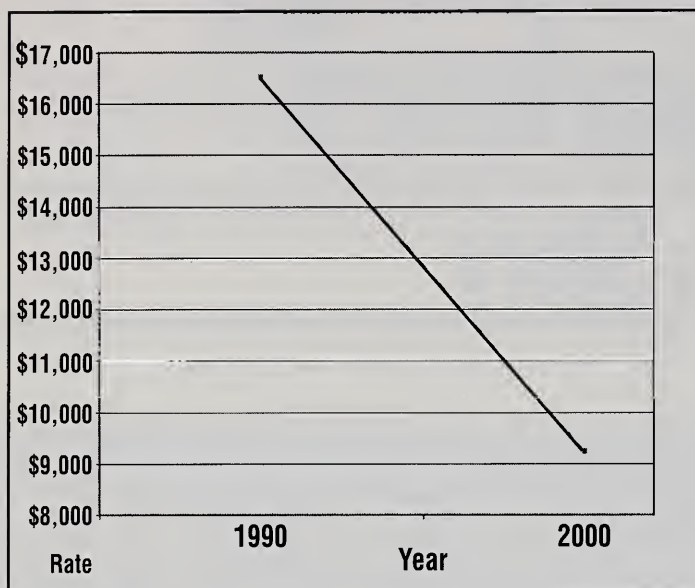


Figure 1. Anesthesiology \$1M/\$3M Rate Level.  
Rate Decrease = 44.1%.

anisms of perioperative nerve injury are clearly understood and no reduction in claims for these injuries may be expected.

**Pain Management.** Although only a small percentage of claims in the database of the ASA Closed Claim Study involve pain management, the proportion of claims attributed to pain management have increased over time.<sup>3</sup> These claims are most often characterized by low-severity or nondisabling injuries in comparison with all other anesthesia claims. Specific injuries relevant to pain management procedures include pneumothorax, nerve damage, headache, and back pain. Few pain management claims involved severe injuries of death and brain damage. Strategies for reducing liability associated with pain management procedures may include better patient education regarding common risks and side effects, careful documentation of consent, and effective protocols for follow-up care.

**Office-Based Anesthesia (OBA).** As clinical practice patterns change, anesthesiologists and nurse anesthetists will increase their participation and experience with office-based anesthesia. OBA has been facilitated by the introduction of short-acting anesthetic drugs that are

associated with minimum side effects and that usually permit rapid awakening and recovery. However, compared with acute care hospitals and licensed ambulatory surgical facilities, office-based facilities currently are covered by few, if any, regulations, oversight, or control by federal, state, and local laws. It must be emphasized that the standard of care in an office surgical suite should be no less than that of a hospital or an accredited ambulatory surgery center. Therefore, anesthesiologists must personally conduct investigations of areas and functions that would be taken for granted in the hospital or ambulatory surgical facility.

Anesthesiologists have a long record of leading risk management and patient safety efforts, and the ASA's *October 1999 Guidelines for Office-Based Anesthesia* proves timely and useful.<sup>4</sup> The *Guidelines* provide recommendations for key areas of clinical care facility administration and physical site safety for anesthesia in the office setting. These recommendations go beyond direct patient care and address areas such as fire safety, equipment needs, and emergency response capability, all to help promote a safe level of anesthesia care wherever that care is rendered.

The New Jersey Board of Medical Examiners has also established surgical and anesthesia standards of practice. The regulations require physicians who perform office-based surgery or anesthesia to have hospital privileges or alternative credentialing. There are strict controls for the administration of anesthesia, safety and maintenance requirements for anesthesia machines, the reporting of untoward events, and the availability of emergency equipment and supplies. General anesthesia can be administered or supervised only by a credentialed physician or anesthesiologist who is not simultaneously involved in the surgical procedure.

Clinicians are encouraged to develop information and educational materials that enhance the safety and quality of patient care, reduce the likelihood of an

adverse event, and help in the defense of cases that may arise despite an appropriate standard of care. Other professional societies, such as the American Academy of Dermatology and the American Society of Plastic and Reconstructive Surgeons, have also been involved in efforts to improve the safety of office-based surgery.

## MINIMIZING YOUR LIABILITY

Health care providers in certain specialties and services run a higher risk of becoming the target of a claim than others. It has been shown that anesthesiologists are more likely to be sued than primary care physicians. Perhaps the most significant reason for this is that patients are unaware of the anesthesiologist for most of the time the anesthesiologist is caring for them. The doctor-patient relationship is therefore tenuous, and involvement with the patient's family is sparse, if there is any at all. The best way for a physician to avoid problem situations is by incorporating risk strategies into daily practice. The following strategies have been designed to minimize liability of the anesthesiologist to the likelihood of claim exposure:

- **Improve the doctor-patient relationship**—Improve contact especially with patients who seem unusually anxious, ill, or prone to a specific complication. Establishing a good rapport with the family may also have a substantial medicolegal prophylactic value. If a complication occurs that may be related to anesthesia, active follow-up is vital and full explanations should be offered.
- **Adhere to standards of care**—Keep current on specialty-specific issues and provide medical care consistent with this knowledge. This requires being aware of and conforming to accepted guidelines for the provision of anesthesia care. Adhering to the standard of care means that the choice of agents and techniques is appropriate and that the anesthesiologist is competent in the use of these agents and techniques.

- **Maintain good records**—Good anesthesia care is pointless if it is impossible to tell what was done and when it was done. As a general rule, if it isn't written, it wasn't done. Record pertinent facts as accurately and completely as possible. Never alter records after the fact.
- **Respond appropriately when incidents occur**—Obtain consultations where appropriate and ensure that the most suitable specialist provides continued care to the patient. One of the most overlooked consultations is getting the opinion of another anesthesiologist at the time an adverse event is occurring. Hospital risk managers are trained to intervene when there is a question of liability. They will gather information, offer support for the patient and family, and act as liaison between the family and the physicians involved. Anesthesiologists should notify them immediately of any incidents that occur. They may be invaluable in decreasing the likelihood of a suit or the damages eventually awarded.
- **Continue to follow the patient**—Patients who are hospitalized after any anesthesia-related incident should be followed until they are appropriately transferred to the service of another physician. Failure to do so

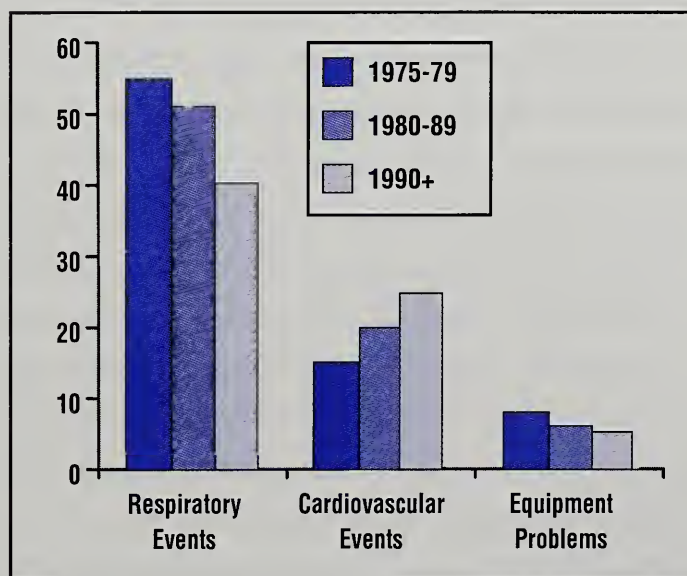


Figure 2. Percent of Total Claims for Death or Brain Damage in Time Period—ASA Closed Claim Study.



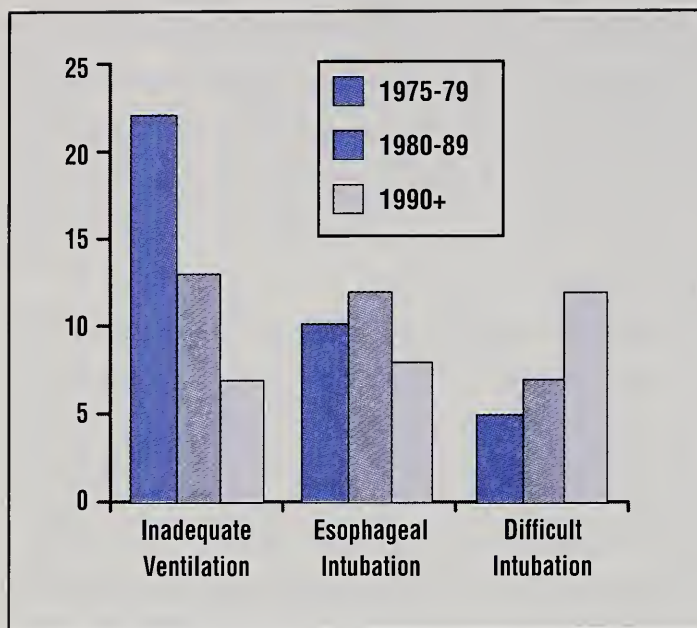


Figure 3. Percent of Claims for Death or Brain Damage in Time Period—ASA Closed Claim Study.

might be construed as abandonment and indicates disinterest and disregard for their welfare.

- Avoid vicarious liability—Instructions given to nurse anesthetists, circulating nurses, and others may be forms of exposures to vicarious liability. Generally, if anyone assists the anesthesiologist or acts on his or her instructions, the anesthesiologist may be considered as supervising them and is liable for their actions. When supervising nurse anesthetists, the anesthesiologist has the right to control their actions. The anesthesiologist is ultimately responsible for the safe administration of the anesthetic and is therefore entitled to the final decisions involved in the care of the patient.
- Do not agree to supervise more simultaneous cases than can be safely handled—If an anesthesiologist is supervising a case and is not available during an emergency or has not been supervising closely enough to prevent an adverse result, issues of inadequate supervision and patient abandonment are allegations that may be difficult to defend.

Theresa V. Arnold is a senior risk management consultant with MIIX Healthcare Group in Lawrenceville.

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# Hospital Divestiture of Physician Practices

*Robert S. Burney, Esq.*

One of the phenomena of health care during the 1990s was the increased acquisition of physician practices—particularly primary care practices—by hospitals. Medical practices have been purchased throughout the country by hospitals of all types and sizes, large and small, for-profit and nonprofit. The Inspector General of the United States Department of Health and Human Services (HHS) estimates that 62% of general acute care hospitals have purchased or owned a physician practice, a number that increased sharply in the middle of the decade.<sup>1,2</sup> There are growing indications that this trend will be reversed during the new decade—hospitals will be selling medical practices to physicians.

Hospitals have chosen to purchase primary care physician practices as part of an overall strategy of creating integrated health care delivery systems offering a continuum of care,

which can compete effectively with managed care companies and insurers.<sup>3</sup> Ownership of a medical practice allows a hospital to obtain Medicare reimbursement for the primary care services offered by the practice.<sup>3</sup> Another reason for purchasing practices—seldom openly articulated—was to guarantee continued referrals from physicians on a hospital's medical staff. Such a referral stream could be ensured by purchasing the practice and employing the physician. As a hospital employee, the physician could refer patients to the hospital without violating the federal anti-kickback law.<sup>4</sup> Many acquisitions have been defensive—that is, the hospital purchased the practice of a member of its medical staff to prevent the physician from selling to a competing hospital. Such acquisitions often were made on the basis of business plans with overly optimistic assumptions.

In a typical acquisition arrangement, the hospital purchased the

assets of the practice and hired the physician as an employee to operate the practice. The selling physician frequently received a base salary and the opportunity for bonuses based on the production of the practice. Many physicians found this arrangement attractive; it allowed them to cash out the value of their practice while continuing to practice medicine free of the escalating burden of administration.

Unfortunately, many practice acquisitions have proven disappointing for both parties. Physicians who are entrepreneurs at heart often chafe at their roles as employees. Hospitals have found that, in many cases, a purchased medical practice is a financial white elephant. Despite their business acumen, most hospitals have not proven adept in operating office-based primary care practices profitably. The Federal Health Care Advisory Board has found that approximately 84% of hospitals that own practices have reported losses



from the practices and that the average hospital-owned medical practice loses nearly \$87,000 per full-time employee each year.<sup>5</sup> There are various reasons for these losses. From the revenue side, employed physicians—particularly those with guaranteed salaries—often do not have the same incentive to maximize the number of patients they see as they did when they owned the practice. At the same time, the expenses of operating the practice often increase as practice employees begin to ask for the higher salaries and more liberal benefits provided to hospital employees. Finally, there is frequently a learning curve for hospital finance departments, which are not used to the billing and collection procedures of an office-based practice.

These issues have sparked the growing trend toward divestiture of hospital-owned medical practices. This may occur in several ways: a hospital may ask the selling physician to repurchase the practice; the physician may offer to repurchase the practice; or the hospital may issue a request for proposals for the purchase of the practice. While a physician's decision to repurchase a practice may be an easy one, a number of legal rules pose risks both to the selling hospital and to the purchasing physician.

## PRIVATE INUREMENT AND INTERIM SANCTIONS

If a hospital is exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code, it must comply with the private-inurement rules of the Internal Revenue Service (IRS) so as not to jeopardize its tax-exempt status.<sup>6</sup> These rules prohibit certain arrangements between a hospital and a private individual who is an "insider." Physicians on a hospital's medical staff are presumed to be insiders.<sup>7</sup> To comply with the private-inurement rule, the resale terms must be negotiated at arm's length and be commercially reasonable. This includes a price based on fair market value.

Theoretically, a hospital's violation of the private-inurement rule could result in the loss of its tax exemption. However, it is far more likely that a violation would result in the imposition of excise taxes on the purchasing physician and the hospital's administrators. A recent change in the law allows the IRS to impose an excise tax, also known as an intermediate sanction, on certain transactions involving a hospital and so-called disqualified persons.<sup>8</sup> That includes physicians who within the previous five years were in a position to exercise substantial influence over the hospital's affairs, members of

the hospital's board of trustees, heads of hospital departments, and others exercising influence on the hospital's budget.<sup>9</sup> Unfortunately, the examples contained in the proposed IRS regulations do not provide adequate guidance as to when a physician is deemed to exercise substantial influence over a hospital's affairs. For example, it is still an open question whether a physician who is not in a management position—but who does make significant referrals to a hospital—would be deemed to be disqualified. While the proposed regulations do not specifically include the substantial admission of patients in the list of indicia of substantial influence, it is clear that hospitals seek the admission of patients and that those physicians who can make substantial referrals are held in high regard.

The resale of a medical practice to such a disqualified person could result in tax liability if the practice is sold for less than its fair market value. The IRS refers to such a sale as an excess benefit transaction. Thus, it is very important that the parties are able to document how the purchase price was determined and that it is consistent with fair market value. If the parties can justify the price based on a recognized valuation methodology, it would be much more difficult for the IRS to chal-

lenge the sale as an excess benefit transaction.

If the IRS determines that the resale of a medical practice constitutes an excess benefit transaction and that the purchasing physician is disqualified, the physician is subject to an excise tax of 25% of the amount by which the fair market value of the practice exceeds the amount paid by the physician to the hospital. This penalty can be increased to 200% of the excess benefit if the physician does not increase the purchase price to fair market value. In addition, the managers of the hospital would also be subject personally to an excise tax equal to 10% of the excess benefit, up to a maximum of \$10,000.<sup>10</sup>

## THE ANTI-KICKBACK STATUTE

Another law that has an impact on a physician's purchase of a hospital-owned medical practice is the federal anti-kickback law.<sup>11</sup> Simply stated, this law prohibits any payment intended to induce a referral for a service paid by Medicare or Medicaid. If the practice is sold for less than its fair market value, the inspector general could allege that the difference between fair market value and the actual purchase price constitutes a payment to the physician in exchange for future referrals.

While there are several safe harbors for different types of transactions, including the sale of a medical practice by one physician to another, there is no safe harbor to protect a sale by a hospital to a physician. The penalties for violating the anti-kickback law are severe: imprisonment for up to five years, or a \$25,000 penalty, or both, and possible civil monetary penalties. In addition, a health care provider can be excluded from participation in the Medicare and Medicaid programs if the inspector general of HHS determines that a violation has occurred. The federal courts are divided on the issue of how much intent is required to violate the anti-kickback statute. The US Court of Appeals for the Third Circuit, which includes New Jersey and Pennsylvania, has interpreted this statute more broadly than most of the other federal courts, ruling that the law is violated if one purpose of the consideration given by a hospital to a physician is intended to induce referrals.<sup>12</sup> For example, assuming that a hospital sells a practice to a physician at less than its fair market value, if the court determines that any purpose—it need not be the primary purpose—of the below-market purchase price was to induce the physician to make referrals to the hospital, the entire difference

between the fair market price and the actual purchase price constitutes an unlawful kickback. The United States federal courts are divided on the issue of whether the government must prove that the parties intended to violate the anti-kickback law.<sup>13</sup> Unfortunately, the Third Circuit has not expressed itself on this important issue, which means that hospitals and physicians in the Third Circuit could face liability even for unintentional violations of the law.

## NEED FOR PROPER VALUATION OF PRACTICE

To minimize the risk of violating the inurement and intermediate sanction rules and the anti-kickback law, the purchase price of the practice being sold should be determined based on a recognized valuation methodology, such as the business enterprise valuation approach approved by the IRS.

One unresolved valuation issue pertains to a practice that is losing money for its hospital owner. If an income approach is used for establishing value, the practice arguably is worthless. However, if one considers the cause of the loss and the effect of the sale to the physician, such an argument is dubious. A physician contemplating purchasing a medical practice from a hospital should consult with a qualified valuation con-



sultant, as well as with experienced health care counsel.

## CAN A PHYSICIAN BE COMPELLED TO REPURCHASE?

It is unclear whether a physician can be compelled to repurchase a practice. If a hospital believes that a purchase of a practice from a physician may violate an anti-kickback law or private inurement rules, it may seek to unwind the purchase by requiring the physician to repurchase the practice. Many purchase agreements contain a blow-up clause providing that, if the sale could be construed as violating applicable law, the parties will agree to renegotiate the terms; and if the parties are unable to agree how to restructure the sale so that it complies with applicable law, the hospital can terminate the transaction. Even if the purchase contract does not contain such a provision, a hospital seeking to divest a practice may be able to rely on the common law rule that a contract that violates the law is void. Although most hospitals would prefer not to seek to compel a member of their medical staffs to repurchase a practice, the extent of financial losses may in some instances leave the hospital little choice but to pursue a nonconsensual solution. This issue will undoubtedly find its way into the courts and provide additional work for health care lawyers.

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3. OIG Report, p. 6.

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5. Health Care Advisory Board 1999 Annual Meeting Report. Stopping the bleed—reversing losses on owned practices, p.18.

6. Section 501(c)(3) of the Internal Revenue Code (IRC) requires that, for an organization to be exempt from federal income tax-

ation, "... no part of [its] net earnings [may] inure to the benefit of any private shareholder or individual."

7. General Counsel Memorandum 39,862 (Nov. 22, 1991). The IRS has, to some degree, softened this position. It has since indicated that insiders are those "individuals whose relationship with [the hospital] offers them an opportunity to make use of [the hospital's] income or assets for personal gain." IRS Examination Guidelines for Hospitals, 1992-22 Internal Revenue Bulletin 59; Revenue Ruling 97-21 (May 5, 1997).

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11. 42 USC Section 1320a-7b(b).

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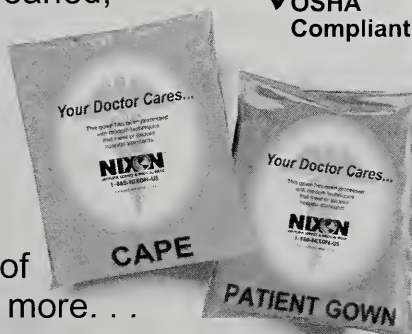
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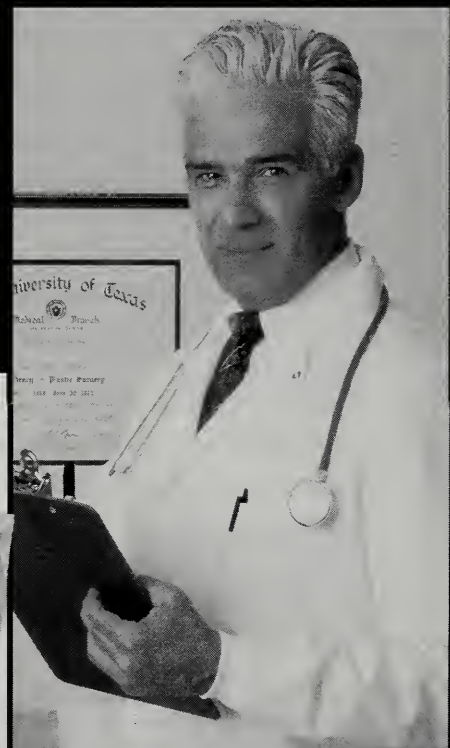
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# The Somerset County Medical Society and the Evolution of Physician Certification

Henry H. Sherk, MD

Who should practice medicine? Who decides who does? These are questions that New Jerseyans have puzzled about for more than 300 years. Nowadays, the role of the state Board of Medical Examiners seems well established and taken for granted, but the questions still have weight, given the efforts of individuals who are not medical doctors to practice medicine in such disparate disciplines as podiatry, midwifery, and optometry.

During its earliest years, the colony of New Jersey existed under English law, which had in fact considered licensure and certification for medical practitioners. The 1665 charter of the Duke of York, for example, held that "those who are employed about the bodies of men, women, or children, for the preservation of life or health . . . [must not] act contrary to the known approved role of art in each mystery or occupation." Under this charter, licenses were apparently granted to surgeons and physicians in New Jersey throughout the late 17th and early 18th centuries by the royal governor or his designee. One, Richard Smith of Burlington, received his from Lieutenant Governor Richard Ingoldsby in March 1705. The certificate still exists and reads as follows:

To Richard Smith, gentleman,

Greeting

Being well informed of your Knowledge, skill, and Judgment in the practice of Chirurgery and Physig, I do hereby lycence and Authorize You to practice in the said sciences of Chirurgery And Physig within this, her majesty's Province of New Jersey . . .

Rich: Ingoldsby<sup>1</sup>

The criteria for admission to the ranks of licensed physicians were not clear, and it must be acknowledged that the treatment of the sick and injured was largely chaotic and irrational. Poultices of crushed ladybugs for the treatment of rashes and toothaches, blistering with mustard plasters, purgings, bleedings, and clysters (massive high-pressure enemas) were standard and accepted remedies for almost any ailment. The many causes and true nature of human suffering were essentially unknown.

By the mid-18th century, the sciences of anatomy, pathology, physiology, and epidemiology, begun by such investigators as Morgagni in Italy, Hunter in Great Britain, and Laennec in France began to have an impact on physicians in New Jersey. John Morgan, among others, visited these early investigators and brought back to



America ideas that began to replace the nonscience of early medicine.<sup>2</sup>

Thus it was in July 1766 that a group of physicians came together in New Brunswick, New Jersey to establish the Medical Society of New Jersey for the purpose of "their mutual improvement, the advancement of their profession, and the promotion of the public good."<sup>3</sup>

The society rather quickly established itself as the essential component of the certification process, however, and admission to medical practice could be achieved only through its approval. At the society's urging, in 1772 the New Jersey Colonial Legislature passed a law establishing the rules for licensure to practice. This was the second medical-practice law, following one passed by the New York Legislature a few years earlier. New Jersey's law held that anyone desiring to practice medicine in the colony must obtain a license from two judges of the Colonial Supreme Court, and the judges in turn would be advised as to the suitability of the applicant by two members of the Medical Society of New Jersey. To practice legally in New Jersey, the applicant also needed to become a member of MSNJ and pass an examination given by the Board of Censors of the society. Thus, the members of the medical profession essentially controlled who could be admitted to practice, since licensure by the Supreme Court justices appears to have been pro forma.

Although the legislature made minor modifications in the system (e.g., in 1783 the examination was codified), MSNJ controlled certification for many years. Medical practitioners who were not members ran the risk of legal penalties for practicing without a license, and certified

**Poultices of crushed ladybugs for the treatment of rashes and toothaches, blistering with mustard plasters, purgings, bleedings, and clysters (massive high-pressure enemas) were standard and accepted remedies for almost any ailment.**

physicians who were guilty of professional negligence or malfeasance faced the discipline of expulsion from the society and consequently loss of licensure.

By 1807 the apparent difficulty of suitably examining the large number of applicants prompted the society to petition the legislature for a change in the law. The lawmakers quickly passed "an act to ratify and confirm the proceedings of the Medical Society of New Jersey." In so doing, MSNJ was empowered to create eastern and western districts, meeting in New Brunswick and Burlington, respectively. The district societies were given authority to admit members, who were then automatically granted membership in MSNJ and thereby became legal practitioners in New Jersey.<sup>4</sup>

The law changed again in 1816, when the state legislature reincorporated the

Medical Society of New Jersey, granting it the authority to form county societies, which in turn had the authority to examine candidates for licensure. If approved by the county, the applicant could receive a license from the president of MSNJ and legally practice medicine within the state. This law made it necessary for legally licensed practitioners to form county societies as quickly as possible, and the first county to do so was Somerset. Acting under the law, which stated that "physicians or surgeons of known skill, learning, and integrity, in each county . . . shall form themselves into a society,"<sup>5</sup> Drs. Peter Stryker, Ferdinand S. and Henry Schenck, William M. and William D. McKissack, James Elmendorf, Augustus R. Taylor, E. Fitch-Randolph Smith, and Moses Scott met in Somerville on May 21, 1816, to form the first county medical society

in New Jersey. At that meeting, they elected officers and drew up bylaws. Fortunately, they maintained careful records. Their recorded minutes and published bylaws reside in the office of the society and in the office of the Somerset County clerk and are still available for perusal and review. The bylaws provide for the election of the usual officers (president, vice-president, recording and corresponding secretary, and treasurer), but the real purpose of the society is described in Article VIII, concerning the Board of Censors. The society would appoint five individuals to this board, but how they were selected was ambiguous. The original minutes state that five censors would be chosen by ballot at each anniversary meeting of the society, but an unknown person crossed out the section, and how the censors were to be appointed was not made clear. Published bylaws of later years do not address this issue. Nevertheless, the 1816 bylaws state:

Not less than three censors shall constitute a board for examining all students who shall present themselves for that purpose and shall report to the President of the Medical Society of the State of New Jersey and, also, to the President for the County of Somerset, their opinion in the form of a certificate within ten days after the examination. It shall be the duty of the Board of Censors to examine all students for admission to the practice of physig and chirurgery on the following branches of medicine, viz.: materia medica, pharmacy, anatomy, physiology, surgery, theory and practice of physig, mid-wifery, and chymistry. They shall not extend their examinations to more than three hours on each particular branch or department of the profession. All examinations of students to practice physig and chirurgery shall be public.<sup>6</sup>

This article carried the weight of the law of the state of New Jersey and gave the practitioners, who were members of the county society, enormous authority

over who could and who could not practice. It made it possible for an applicant to undergo as many as 24 hours of public grilling on the necessary subjects and seemed to offer no second chance or opportunity to appeal adverse outcomes to the examination process.

The original bylaws do not address the issue of withdrawal of certification, except for the following in article XXI: "It shall be considered dishonorable and worthy of censure for any member of this society to hold professional intercourse with irregular bred pretenders to medicine, illegal practitioners, or expelled members."<sup>6</sup> It was also stated that a censured member "shall be suspended or expelled from the society" by a vote of three-fourths of the members present.

Thus, in 1816 the most serious offense a physician could commit was "professional intercourse" with a medical practitioner outside the society. This, of course, meant seeking professional referrals from homeopaths, herbalists, Thomsonians, faith healers, and others. Activity of this sort was subject to the most serious penalty possible,

namely expulsion from the society and loss of license to practice.

Several years later, the Somerset County Medical Society published bylaws that address this issue more thoroughly, as follows:

No member of this Society shall be dismissed, except on conviction of:

Gross, palpable, or repeated errors in practice through ignorance or negligence.

Conduct glaringly unbecoming the character of gentlemen and members of a liberal profession.

Gross, repeated, and disgraceful acts of immorality.

Gross and repeated violations of duty as members of this Society (official or unofficial).<sup>7</sup>

Somerset County's Medical Society was the first but not the only society for very long. Monmouth, Essex, Morris,

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and Middlesex County physicians formed county medical societies in the same year, 1816, one or several months later. The essential purpose of each of these was the same: to provide a mechanism for the examination and certification of doctors, thereby protecting the public from physicians perceived to be "irregular practitioners." There may also have been at least some self-interest in these arrangements, however, since the societies published their proceedings in the newspapers, thereby letting the public know who was and who was not a licensed physician and member of the Medical Society of New Jersey.

In addition, the county society system of licensure gave rise to jurisdictional disputes. For example, in June 1829 the minutes of the meeting of the Morris County Society were copied and sent to the Somerset County Medical Society, protesting the certification of Waldo Brown:

Whereas it appears, to the satisfaction of this Society, that Waldo Brown was examined by the censors of this Society, 2nd October, 1826, and was refused a certificate for want of a proper knowledge of the medical profession, did within the space of about a week, thereafter, applied to the censors of Somerset District, for another examination, with certain other young men, and received from said censors a Certificate of Qualification, upon which a license to practice was granted, contrary to the express rules and regulations.<sup>7</sup>

The resolution from Morris goes on at length about Brown's "insolent letter to the Morris censors, accusing them of falsehood and malconduct," and after a lengthy preamble, Morris County strongly urges that Somerset address this issue. There is nothing in the available minutes of the Somerset Society about what was done, if anything.

The county societies and the Medical Society of New Jersey continued to certify applicants for licensure under the 1816 law until 1851. In that year, lobbying by the edu-

**Spurious medical colleges and diploma mills sprang up from which unqualified individuals could purchase fake certificates.**

cational establishment through the American Association of Colleges prompted the legislature to modify the law so that graduates of five medical colleges were automatically exempt from the licensing process of the county societies and MSNJ. Thus, individuals with a diploma from the University of New York, the University of Pennsylvania, Jefferson Medical College, the Pennsylvania Medical College, and the College of Physicians and Surgeons of New York could merely pay the necessary

fee and become licensed. Three years later, the legislature changed the law again, to allow any individual with a diploma from any medical college in the United States to practice in New Jersey. The county medical societies and MSNJ were stripped of their authority and power, although MSNJ was left with the authority to grant an MD degree, an authority it maintained until recent years. The educational establishment had taken over the county and state societies' role in the certification process, and gaining a diploma from any medical school was the only hurdle would-be practitioners had to master. What had seemed like a good idea to the lawmakers rather quickly turned into a scandal. The law stated that an applicant must have satisfactorily completed 12 weeks in courses on various specified medical subjects, but the quality of the courses, who presented them, and whether the applicant even attended the courses, was not known. Spurious medical colleges and diploma mills sprang up from which unqualified individuals could purchase fake certificates. With a meaningless document, such individuals could, under state law, register at any county courthouse as legally licensed physicians and open an office to practice. Lobbying by the educators had paid off handsomely, but the public was ill served.<sup>8</sup>

Despite an 1883 law making the use of a fraudulent diploma unlawful, the number of physicians in New Jersey grew rapidly and the quality of medical care and the repu-

tation of the profession collapsed as a result of this legislation. This result was especially unfortunate in that the science of medicine was on the threshold of its modern configuration. Lister, Koch, Pasteur, Bernard, and many other 19th-century investigators were in the process of taking medical care out of the realm of mystery (not to mention quackery) and basing it on firm scientific and rational theory. There was a serious need for qualified men and women to enter the profession and to receive appropriate certification.

In 1884 the American Medical Association adopted a resolution "urging upon American medical colleges, the necessity of elevating the standard of education, at least so far as to require a preliminary examination, a three-year course of study, a registration of attendance, and practical demonstrations in physical diagnosis." Surprisingly, these resolutions were "bitterly opposed" by the Association of American Colleges. Nevertheless, the legislators took the resolution seriously and in 1890 established the state Board of Medical Examiners. This act, passed on May 12, 1890, gave the governor of the state the authority to appoint "five old-school physicians, three homeopathic physicians, and one eclectic physician" to constitute the board.<sup>9</sup>

The act took certification out of the hands of the colleges and placed it firmly under the jurisdiction of the executive branch of state government, where it resides today. This system has endured remarkably well, despite the radical changes in medicine and society. In our profession, the various schools of practice (allopathy, homeopathy, eclecticism, osteopathy) have all more or less evolved into modern clinical medicine, but unpredicted and rather dramatic changes have taken place in the science and practice of medicine, and these will continue to occur as science advances. So far, the board has adapted to changing times.

Today, other nonmedical practitioners seek licenses to engage in therapeutic

endeavors with qualifications and training that differ from those of traditional medical practitioners, and these issues are being addressed by the legislature through the New Jersey Board of Medical Examiners. They make one realize that licensure and certification are not static concepts. Since in our time adaptation and change also often seem to come at the cost of disagreement and some pain, it makes us appreciate and respect the steadfast efforts of our predecessors in the Somerset County Medical Society 184 years ago. They did their best with what existed for them in their time and place.

*Henry H. Sherk is historian of the Camden County Medical Society; author of Colleagues & Competitors: 150-year history of the Camden County Medical Society; and professor of orthopaedic surgery, Medical College of Pennsylvania Hahnemann University, Philadelphia PA. The author wishes to thank the officers and members of the Somerset County Medical Society (the first county medical society in New Jersey) for making their minutes and other records available for the preparation of this article.*

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**This system has endured remarkably well, despite the radical changes in medicine and society.**



# New Jersey Medicine Reviewers

Peer-review is critical to our process of evaluating manuscripts that are submitted to *New Jersey Medicine*. Each manuscript received is sent to at least two peer-reviewers, who recommend whether it should be rejected, accepted, or revised. Specific suggestions for revisions are made to guide and assist the author. Revised manuscripts are again reviewed. This process is time-consuming but necessary for any medical professional publication. We are grateful to our reviewers, who make this publication possible. Those who have been reviewers in 2000 are listed below, with the thanks and appreciation of the editorial board.

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# Aetna US Healthcare FAQs

**O**n August 6, 1999, Aetna US Healthcare entered into a consent order with the state of New Jersey. The consent order allowed Aetna's acquisition of Prudential Healthcare to go forward in New Jersey under 30 conditions designed to protect patients and consumers and ensure a competitive HMO market.

In the following months, senior Aetna medical directors and other executives in the Pennsylvania-New Jersey region began to meet regularly with MSNJ representatives. Through these meetings, both sides hope to narrow the gap that separates the interests of the state's physician community and Aetna's policies.

Early in these discussions, the MSNJ and Aetna teams agreed on the importance of improving communication between our community and the state's largest HMO. To this end, Aetna furnished written answers to numerous questions submitted by MSNJ. The questions represent concerns frequently raised by physicians and physician advocates.

The first set of these questions and answers appears here. *New Jersey Medicine* will publish the second set next month. Additional questions and answers are posted on MSNJ's Web site, [www.msnj.org](http://www.msnj.org).

MSNJ members are welcome to offer suggestions to the team that is meeting with Aetna. Team members include: Walter J. Kahn, MD, president; Irving P. Ratner, MD, immediate past president; Jerome A. Molitor, MD, vice-speaker, House of Delegates; Joseph W. Sokolowski, Jr, MD, chair, Medical Review and Accrediting Council, Inc. (MRAC); David E. Swee, MD, chair, Council on Medical Services; and Neil E. Weisfeld, deputy executive director.

## **How can physicians work with the Aetna US Healthcare formulary and pharmacy department to ensure efficient approvals on medications?**

Aetna US Healthcare's formulary is based on the clinical effectiveness, safety, and overall value of various pharmaceuticals.

Aetna US Healthcare's goal is to provide a formulary that gives members access to medically necessary

medications at an affordable cost. Aetna US Healthcare offers customers both open and closed formulary options, in addition to several tiered copayment benefit plan designs. Customers choose a benefit plan based on quality, cost, and access. Many of our benefit plans contain special requirements under which providers may need to seek approval for a member to receive coverage of a certain medication. These include precertification, step-therapy, and the formulary exclusion medical exception process.

## **Understanding Precertification**

Precertification helps encourage the appropriate, cost-effective use of certain drugs in accordance with current medical literature, manufacturer recommendations, Food and Drug Administration (FDA) guidelines, and available cost information. For these purposes, cost information includes information regarding manufacturer volume discount arrangements under which Aetna US Healthcare receives financial consideration. The precertification requirement applies to medica-



tions that people are more likely to take inappropriately, use in amounts that exceed dosage or length of treatment recommendations, or that may be more costly than medications that have been shown by the FDA, manufacturer, or peer-reviewed literature to be clinically and therapeutically similar. If precertification applies to a member's benefit plan, the doctor must contact the Pharmacy Management Precertification Unit to request prior authorization for the medication. If the request is approved, the drug will be covered. The list of drugs requiring precertification is subject to change.

### Understanding Step-Therapy

Rising prescription drug benefit costs make it more important than ever for pharmacy benefits managers to develop programs to help maintain access to quality, affordable prescription drug benefits. Drugs on the step-therapy list are subject to a different form of precertification requirement under many pharmacy benefit plans. Step-therapy helps encourage the appropriate, cost-effective use of certain medications in accordance with current medical literature and manufacturer recommendations, Food and Drug Administration guidelines, and

available cost information. For these purposes, cost information includes information regarding manufacturer volume discount arrangements under which Aetna US Healthcare receives financial consideration. If step-therapy applies to a member's benefit plan, one or more "prerequisite therapy" medications must be tried before a step-therapy medication will be covered. However, if it is medically necessary for a member to be initially treated with a step-therapy medication, the doctor can contact the Pharmacy Management Precertification Unit to request coverage as a medical exception. If the request is approved, the drug will be covered. The list of drugs requiring step-therapy is subject to change.

### Understanding Exclusions

Drugs included on the Formulary Exclusions List will not be covered for members in the closed formulary benefit plans without the approval of a medical exception. If a member's physician requests a medical exception and the applicable criteria are met, Aetna will authorize coverage. Some examples of exception criteria include but are not limited to allergies to certain drugs, failed use of other drugs, drug interactions, and side effects.

Physicians can contact the Pharmacy Management Precertification Unit. This unit is available 24 hours a day, 7 days a week to request coverage as a medical exception.

*The Aetna US Healthcare Medication Formulary Guide*—available to all practitioners in written form and on the Internet—lists all formulary medications, formulary exclusion medications, and medications subject to precertification or step-therapy.

### What steps should a physician take regarding disputes on reimbursements that are quick and easy?

Physicians should always first review the Explanation of Benefits (EOB), which should clarify the reasons for the denial or partial payment. For questions beyond the scope of the EOB, offices are instructed to call Provider Services (both specialty and primary care physicians) for HMO-based products. For non-HMO based products, physicians are instructed to call the number on the back of the members' identification card for the correct claims processing center. If there is still need for further clarification or discussion, physicians should call their office professional services coordinator (PSC).

**In Aetna's eyes, what makes a physician good? What does Aetna want from physicians?**

Aetna US Healthcare takes great pride in the relationships it has established with our network of participating physicians, recognizing the critical role they play in the delivery of medical services to its members, their patients. Its goal is to work with doctors to improve the quality, efficiency, and effectiveness of the care its members receive. It believes that providing useful information on performance is one tool that can be used to reach this goal. It values relationships with physicians who want to work with it creatively to address the issues facing the health care system, address their patients concerns with compassion and skill, and understand the importance of good communication.

Each physician's license, education, and work history is reviewed by Aetna US Healthcare or in some cases the physician's affiliated group or organization. A committee of participating physicians in each geographical area reviews the information about physicians who want to participate in the network. Because Aetna's goal to help improve quality is an ongoing commitment, participating physicians periodically undergo a recredentialing process.

Aetna US Healthcare's Primary Care Physician and Specialist Clinical Performance Reports, developed by its performance measurement subsidiary, US Quality Algorithms, are just one example of ongoing efforts to help providers deliver quality care to Aetna members. These reports are designed to promote consideration of nationally recognized practice guidelines and preventive screening recommendations promoted by organizations such as the American Heart Association, the American Diabetes Association, and the National Committee for Quality Assurance and to encourage utilization of certain services and pharmaceuticals when clinically indicated. Along with our provider contracts and credentialing criteria, these reports reflect what Aetna US Healthcare expects from participating physicians.

Primary care physicians currently receive clinical performance reports relating to care provided to patients with asthma, diabetes, and cardiac disease and prescription prescribing. Certain types of specialists also receive clinical performance reports with measures relevant to their specialties. Aetna hopes that this cooperative effort with participating physicians will lead to better overall care for its members, their patients.

**What about the "all-products clause" in its provider contracts?**

Aetna US Healthcare has used the all-products contract for several reasons: it maximizes member choice of participating providers; it minimizes the need for members to change providers when changing plans (thereby fostering long-term physician relationships and continuity of care); it minimizes potential member confusion about differing company networks in the same geographic area; and it simplifies and streamlines the contracting, directory development, and other administrative processes.

Some physicians have voiced concern over the all-products clause. This concern is primarily among those who have not previously participated in a capitated product and may not fully understand how this payment system works. Aetna has been reevaluating this approach on a market-by-market basis. ■

### **Aetna Phone Numbers and Web Address**

Pharmacy Management  
Precertification Unit  
(888) 792-8742;  
fax (800) 408-2386.

Provider Services  
(800)624-0756.

<http://www.aetnaushealthcare.com>



# PROMPT-PAY SURVEY

It's been almost a year now since the adoption of New Jersey's prompt-pay law. Regulations now require insurers to pay clean claims within 30/40 days. How are the HMOs doing? Are they living up to the law?

To find out, MSNJ has developed a Prompt-Pay Survey. Scheduled for January 15-20, 2001, the survey will track claims submitted during the week and follow them through the processing period until payment.

So help us help you and participate in the upcoming Prompt-Pay Survey. Return this form to let us know you want to be involved. You'll then receive additional information from MSNJ, including a copy of the survey form, data collection worksheets, and announcements of the survey kick-off program.

## Your Partner in Practice...

Help us help you!

Become a partner in the MSNJ Prompt-Pay Survey,  
and let your voice be heard!

## Your Voice in Trenton

☒ Yes! I want to participate in the MSNJ Prompt-Pay Survey. Send me the survey form and instructions. I understand that the information I provide will remain strictly confidential.

Name (please print) \_\_\_\_\_

Practice \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

Fax to: Karen Cuzzo  
(609) 896-1368

Or mail to: Karen Cuzzo  
MSNJ Prompt-Pay Survey  
Two Princess Road  
Lawrenceville NJ 08648

*Thank you for your interest in the MSNJ Prompt-Pay Survey. You will receive a survey form, instructions, and an announcement of the survey kick-off program!*

## PEOPLE IN THE NEWS

**Robert M. Pally, MD**, was appointed to the Public Health Council and began a seven-year term this past August. He also serves on the American Academy of Family Physicians Commission on Public Health.

**Lee D. Eisenberg, MD**, has received a presidential citation from the president of the American Academy of Otolaryngology—Head and Neck Surgery Foundation for his continuing contributions to the academy and the specialty.

**Umur M. Atabek, MD, FACS**, has been appointed New Jersey state chair of the Commission on Cancer's Cancer Liaison Program.

**Patrick Mahony Foye, MD**, has been appointed medical director of MasterCare Companies.

## HEALTH PLAN PERFORMANCE VARIES BY ENROLLEE ETHNICITY, EDUCATION

Performance on the standardized measures used by health insurers when computing scores through the Health Plan Employer Data Set is influenced by such factors as enrollee schooling, income, and ethnic or racial background. Within each health plan, populations from areas with relatively high percentages of residents on welfare or who were black or Hispanic received generally poorer quality care, while enrollees in urban areas and areas with higher education levels and more Asian-American residents received consistently better care. Details are in the October issue of *Medical Care*.

## NJ ARTISTS HELP FIGHT BREAST CANCER

New Jersey artists have joined with breast cancer experts to design a 2001 Breast Cancer Calendar. The calendar provides helpful information about breast cancer, including reminder stickers for breast self-exam and annual mammogram as well as healthy eating tips and resource information. A suggested \$10 donation for the calendar, made payable to the New Jersey Breast Cancer Research Fund, is tax deductible. For more information, call (609) 633-6552 or visit the Web site [www.breastcancercalendar.com](http://www.breastcancercalendar.com).

## A LATE REQUEST FROM THE CDC REGARDING FLU VACCINE

As *New Jersey Medicine* went to press, the CDC called to ask that a reminder go out to New Jersey physicians to make sure that their patients with diabetes are vaccinated against influenza first. It provided a recap of the reasons.

### Risks for People With Diabetes

- People with diabetes are about three times more likely to die with pneumonia or influenzalike illness than people without diabetes.
- Currently, 10,000 to 30,000 people with diabetes die each year with pneumonia or an influenzalike illness; many of these deaths are caused by influenza or pneumococcal infections.
- According to 1997 Behavioral Risk Factor Surveillance System (BRFSS) results, about half of

adults with diabetes are not immunized against influenza and 2 out of 3 people have not been immunized against pneumococcal disease, the most frequent cause of pneumonia.

### Diabetes and Influenza

- Death rates among people with diabetes increase by 5% to 15% during flu epidemics.
- People with diabetes are more likely to be hospitalized with influenza during influenza epidemics.
- The risk of hospitalization increases when additional risk factors exist, including diabetes and other risk factors such as the presence of cardiovascular disease, renal disease, and older age (65 years or more).

### Diabetes and Pneumococcal Disease

- People with diabetes are more likely to be hospitalized or die from pneumococcal disease than those without any risk condition.

### General Statistics

- Influenza and pneumococcal infections kill an average of more than 25,000 people each year in the US.
- Pneumococcal disease is the most frequent cause of pneumonia.
- Each year, about 60,000 persons have pneumococcal infections that spread to the bloodstream (bacteremia) or brain (meningitis). About 6,000 people die from these infections, including about 4,000 who also have pneumonia.
- About 125,000 persons are hospitalized with pneumococcal pneumonia each year, and about 10,000 people die from it annually.





*Advancing the Practice*

## Physicians Conference 2001

*Physicians and office staff should set aside April 20-22 for next year's Conference, as we build on the success of last year's event. Ours is the only state in the nation to host a comprehensive conference between a state medical society and specialty societies.*

*Compare to other conferences and realize more value with less travel.*

### Here's Just A Sample Of What This Year's Conference Has To Offer:

**Keynote Speaker** Acclaimed speaker Beck Weathers, MD, relives his tale of surviving the deadliest climbing expedition ever on Mt. Everest.

**Educational Instruction** More than 50 clinical, practice management and general workshops. Hear the latest on women's health, diabetes, chronic pain, surgical procedures, office efficiency and compliance...and much more!!

**Exhibit Hall** Visit 200 companies and organizations eager to advance your practice through innovative products and services.

**Physicians Public Affairs Seminar** Come see the New Jersey Board of Medical Examiners discuss important issues related to your medical license.

**MSNJ Annual Meeting** MSNJ's Annual Meeting concludes the day before Physicians Conference, leaving ample time to participate in both events.

**Presidential Gala** Attend this elegant dinner-dance to honor all society presidents and celebrate the medical profession.

**Hotels** The beautiful Sheraton Hotel, adjacent to the Convention Center, serves as the Conference Headquarters Hotel. Other hotels and casinos also available.

**Registrant Packages** Coming soon. Look for more information on conference workshops, exhibitors, and programming in New Jersey Medicine, at [www.msnj.org](http://www.msnj.org), and on your fax machine. Convenient, on-line registration.

**Early registration discounts and one-day packages available.**  
**Physicians-in-training and guests welcome.**

**Visit [www.MSNJ.org](http://www.MSNJ.org) often for updated PC 2001 information!**

## GETTING THE MOST OUT OF msnj.org

**M**SNJ's Web site, [www.msnj.org](http://www.msnj.org), offers a wealth of news information and is a great way to keep in touch with the society and your fellow members. We have been working hard to make it an accessible, useful site for physician members, other health care professionals, and the public.

This month we look at the public side of the Web site and review what you can find there.

Every button and banner on the home page is publicly accessible. Members are invited to click to enter the members-only part of the site on a special button.

## BANNERS

We currently have banners for Physician Finder and Physicians Conference 2001. Physician Finder provides a Web page for every MSNJ member and is searchable by name, specialty, supported insurance, or hospital affiliation. Each page lists the doctor's name, specialty, practice address, phone, fax, e-mail, medical school, degrees, and whether the physician is currently accepting new patients.

Physicians Conference 2001 is a link to pages providing information about the upcoming meeting in April. More on this when we get to that section.

## BUTTONS

The buttons on the left side of the home page are About MSNJ, Physician Finder, Tobacco and Public Health, Our Journal, and Need Help?

**About MSNJ.** When you click on About MSNJ, you are taken to a page

with the following links: who we are, the MSNJ president's message, our accomplishments, a list of the county medical societies, information on how to join, and frequently asked questions. Who We Are lists key staff, the Board of Trustees, and whom to contact at MSNJ for a particular issue. The President's Message is the inaugural address of Walter Kahn, MD, in Atlantic City this past May. Our Accomplishments is a regularly updated list of what MSNJ has been doing for its members and New Jersey residents. County Medical Societies includes information on the same, with links to county society Web sites when available. How to Join includes registration information, an online application form, and special information for medical students and residents. FAQs includes more information about MSNJ as well as some useful links to the AMA and the Board of Medical Examiners.

**Physicians Finder.** The Physicians Finder button links to the same database as the banner on the home page.

**Newsroom.** Newsroom offers links to Hot Off the Press, Media Releases, the Annual Convention, Ask a Question, and Suggested Links. Hot Off the Press contains breaking news of interest to the medical and general community. Often these stories are then moved to Media Releases, which also publishes MSNJ press releases and other information. The Annual Convention contains links to Physicians Conference 2001, the program, registration, and sponsors. These are updated throughout the year

as more information becomes available. Ask A Question allows any visitor to e-mail MSNJ. Suggested Links offers links to selected medical, health care, governmental, and other Web sites. (Suggestions to adding to this page are welcome; send them to [info@msnj.org](mailto:info@msnj.org).)

**Tobacco and Public Health.** The Tobacco and Public Health page offers links to Tobacco Control and Public Health, which post news and information related to these areas and contain links to NJBreathes and the NJ Department of Health and Senior Services.

**Our Journal.** Our Journal contains the Current Issue, Subscribe, Classified Ads, Index and Past Issues, Featured Article, In Memoriam, and Advertise. The Current Issue contains the table of contents for *New Jersey Medicine* as of the first of every month (the publication doesn't mail until the fourth or fifth). Subscribe lists the goals of *New Jersey Medicine* and offers an online subscription form as well as a way to subscribe via e-mail. Classified Ads are updated monthly. The Index and Past Issues page contains information about ordering back issues and a cumulative index (since 1999) of articles in *New Jersey Medicine*. As of 2000, there is also an author index. The Featured Article is an article that may be of interest to the general public as well as the physician community. In Memoriam, which is published four times a year in *New Jersey Medicine*, is updated monthly on the Web site. Advertise provides information on advertising in the journal and on the Web site.



**Need Help?** This section offers a site map to the entire site, a site search function, an online contact form, and help with signing in as a member.

Next month we'll start looking at the members-only portion of the Web site, which contains even more information and news.

#### EMPLOYERS AND JOB SEEKERS TAKE NOTE

As of January 2001, the classified advertising section of the Web site of the Medical Society of New Jersey will be placing "Situations Wanted" advertising from all job seekers in the health care industries free of charge.

Send e-mail to [info@msnj.org](mailto:info@msnj.org) with a subject line of "Job Seeker." Briefly describe the type of job you are looking for and the area in New Jersey you would prefer to work (or your willing-

ness to relocate to another part of the state), and list your qualifications, also as briefly as possible. The site will not be posting résumés or CVs. It will not be posting information for people looking for jobs outside New Jersey (however, it will accept queries from those currently out of state looking to relocate). If you wish, include contact information about yourself so that employers can contact you directly. However, if you wish to remain anonymous and contact the employer yourself, that can be arranged.

We cannot accommodate faxes or paper mail; the information must be in electronic form.

The ad will stay up until you contact [info@msnj.org](mailto:info@msnj.org) to take it down.

To view the page on which ads will be placed, go to [www.msnj.org](http://www.msnj.org), click on

"Our Journal," click on "Classified Advertising."

All rates for advertising in the print *New Jersey Medicine* remain as listed on the rate card. All rates for other advertising online remain as listed on the Web site.

#### KEEP YOUR E-MAIL ADDRESS UP TO DATE

Recently MSNJ sent out its first e-mail alert. Quite a few of the e-mail addresses were undeliverable. Remember, if you change your service provider or your address name, you need to send it to us again. To join the list, go to [www.msnj.org](http://www.msnj.org), click on "Members Click Here," enter your user name and password, and you will be taken to the Member home page, where you can send us your e-mail address.

For the  
**LATEST**  
LEGISLATIVE NEWS  
POLICY STATEMENTS  
PRESS RELEASES  
and more...

go to [www.msnj.org](http://www.msnj.org)

# Protecting Study Volunteers in Research

## A Manual for Investigative Sites

Cynthia McGuire Dunn, MD, and Gary Chadwick, PharmD, MPH

Boston: CenterWatch 1999

250 pp, \$59

ISBN 0967302919

Recent media reports of scientific misconduct and failure to comply with federally mandated research subject protections have focused attention on the importance of training in research ethics and regulation for investigators and members of institutional review boards. Recently, the US Department of Health and Human Services has announced several initiatives designed to strengthen protections of human research subjects, heighten government oversight of biomedical research, and reinforce the responsibilities of investigators to follow

internationally accepted ethical standards and federal guidelines.

In this context, the appearance of Dunn and Chadwick's resource manual, *Protecting Study Volunteers in Research*, is both timely and welcome. As the authors state in the Preface, "Violations in research ethics are generally caused by lack of awareness rather than malice." This manual is intended to aid researchers in understanding both the regulatory requirements and the ethical principles on which they are based.

The first chapter provides a compelling historical background, which serves as a basis for federal regula-

tions in research and explains how compliance with these regulations promotes human subject research protections. The authors identify three major events that had a significant impact on this process: the 1946 Nuremberg doctors' trial, the 1960s' thalidomide tragedy, and the 1972 Tuskegee syphilis study exposé. Also alluded to are several other events, each in its own way illustrating how the public's perception of research is shaped by the way research is conducted.

The next chapter describes how, in 1974, Congress passed the National Research Act, creating a



National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The commission promulgated principles and guidelines (commonly known now as the Belmont Report) that addressed the conviction that individuals should be treated as autonomous agents and took special note of those with diminished autonomy, such as children, persons with cognitive disorders, and prisoners, as needing particular attention in this regard. Issues such as informed consent, risk and benefit assessment, and the equitable selection of subjects are considered, culminating in the role of institutional review boards (IRBs) to ensure the proper conduct of clinical research.

Subsequent chapters deal with the roles and responsibilities of institutions and investigators in conducting successful and creditable research and the process by which this is accomplished, namely the creation of a protocol, or study design, that explicitly outlines how the study is to be carried out and how subjects may be protected from

risk and exploitation. Here we learn that principal investigators are responsible for recruitment of subjects and for their safety and welfare during the trial. Although the principal investigator may delegate some responsibilities to other members of the research team, that person is ultimately responsible for the integrity and the conduct of the study.

Subjects covered in additional chapters include FDA-regulated research issues, special considerations of behavioral research, and managing potential conflicts of interest in the publication of study results.

A special feature of the book is the inclusion of several useful appendices. Pertinent references, resources, and suggested readings provide additional depth and documentation. The Belmont Report is published in its entirety. Relevant portions of the Code of Federal Regulations are also included. Finally, there is a handy glossary and table of abbreviations.

One of the unique features of this book is the inclusion of a series of

examination questions and provisions for obtaining continuing education credit. This is especially important because of forthcoming requirements for an accreditation process for IRBs and for investigators. These methodologies for ensuring compliance will likely become more rigorous in the future.

This utilitarian manual will serve as a coherent guide to the proper conduct of clinical research in an increasingly regulatory environment.

**Arthur Krosnick, MD**, is medical director of AMP Diabetes and Education Consultants in Princeton and clinical associate professor at Robert Wood Johnson Medical School.

**Alan Lippman, MD**, is chairman, Institutional Review Board at Newark Beth Israel Medical Center.

# Forged by the Knife

## The Experience of Surgical Residency from the Perspective of a Woman of Color

Patricia L. Dawson

Seattle WA: Open Hand Publishing, 1999

176 pp., \$15.00 paper/\$24.00 cloth

ISBN: 0940880644 paper/0940880636 cloth

**F**orged by the Knife explores the methods used by women of color to overcome actual or perceived gender and ethnic obstacles encountered during their training years. As an example of heuristic research, in which the examination of a particular phenomenon leads to further investigation, this exploration provides perhaps compelling evidence of overt discrimination against a sometimes vulnerable group of committed health professionals and a challenge to address their needs and to encourage more minority women to join the crusade for better health care in our underserved areas.

Although the author describes her own experiences rather cryptically

and unemotionally, she brings zest and a wealth of detail in recounting the experiences of six selected survey respondents whom she identifies as Diane, Janice, Joyce, Marie, Hazel, and Xena.

While Dr. Dawson was attending medical school in New Jersey 23 years ago, she encountered no black female surgeons. She also had little or no contact with other black female trainees. She found female surgical faculty not particularly supportive in addressing her emotional needs or in encouraging her professional development.

Following her departure from New Jersey and move to a program on the West Coast, the author found

a paucity of blacks on the staff of the new medical center and, again, no ideal "role models" after which to pattern her conduct. For much of her residency, therefore, she felt isolated, having no one to share her concerns, and felt a great deal of pressure to perform in a superior fashion.

Current statistics reveal the number of black women surgeons in the US is exceedingly small, accounting for a mere 0.0005% of all general surgeons (about 1 in 2,000). Previous anecdotal research by others has revealed that black women surgeons have felt discriminated against more because they were female rather than because they were black.



To develop greater insight, the author conducted a survey. After identifying a cohort of prospective subjects, she mailed 110 survey instruments to her study population. Forty-nine were returned, of which 30 contained useful data. After excluding residents, fellows, surgeons practicing for more than five years, and those no longer in practice, the study sample dwindled to eight surgeons suitable for detailed interviews. Of these, six were conducted.

The first individual, Diane, described her residency experience as one in which she had to prove herself as competent and credible, without the support mentoring may have provided. In a program that valued toughness and stamina, she noted that women were discriminated against, as exemplified by what were perceived as unfair demands placed on those asked to cover colleagues out on maternity leave and, in one particularly notorious episode, a situation in which she personally was subjected to a form of physical abuse by a presumably sadistic cardiothoracic surgeon.

The next individual, Janice, describes similar experiences but

believes the demands made her a better person. Joyce's experiences seemed less harsh. Coming through a program where she felt bonded with her coresidents, she states she worked hard, stayed focused, and now enjoys her practice.

Marie describes having had the opportunity to train with some of the best-known surgeons of her time and worked hard. Despite that, she believes her communication skills were acquired in her early upbringing, having less to do with her residency experience. She says: "In surgery you've got to be fast, focused, flexible, and—in my family—faithful. And it sure helps if you are female."

Hazel reported instances of discrimination and having to perform satisfactorily for superiors whose conduct she did not respect. This resulted in her becoming more assertive, more self-conscious, and, perhaps, less tolerant. Xena also felt she was a victim of discriminatory practices (she seemed to be on call for every holiday) and felt abused by her program director who, she claims, threatened her in an unwarranted fashion.

In analyzing these vignettes and relating them to her own experiences, Dr. Dawson postulates the following coping mechanisms: complete immersion and devotion to task, focusing on the work at hand to the exclusion of other pursuits; denial, or emotional blocking; and transcendence, which she describes as an uplifting experience to surmount the punishing daily routine.

The book is timely and relevant. While the author trained during a period that afforded little peer contact, those who followed had greater opportunity to be influenced by role models to help shape their attitudes. In the current health care environment, with numerous negative incentives for individuals to enter the health sciences, it would be desirable to make residency programs more appealing, more humane, and less demanding of self-sacrifice. Furthermore, positive efforts should be made to encourage more minority females to pursue careers that would enable them to better serve our underrepresented urban communities.

**Dione Williams, MD, PhD, FACS,**  
*is in private practice in Maplewood.*

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| <b>Challenges in Primary Care Medicine</b>                           | December 15-16 | New York Hilton & Towers,<br>New York NY, (925) 969-1789               |
| <b>Dermatology for the Nondermatologist</b>                          | December 15-17 | Grand Hyatt, New York NY,<br>(800) 421-3756                            |
| <b>New York Cardiovascular Symposium</b>                             | December 15-17 | New York NY, (301) 897-2694                                            |
| <b>Specialty-Specific Outcomes Analysis<br/>and Pediatric Trauma</b> | December 16    | UMDNJ-Medical School,<br>Newark NJ, (609) 896-1901                     |
| <b>17th Annual Clinical Update of<br/>Pulmonary Disease</b>          | December 16    | Sheraton Atlantic City, Atlantic City NJ,<br>(609) 893-1200, ext. 5364 |
| <b>Lower Genital Tract</b>                                           | December 17-20 | Marriott Marquis, New York NY,<br>(215) 542-3838                       |
| <b>MSNJ Board of Trustees Meeting</b>                                | December 17    | Lawrenceville NJ, (609) 896-1766                                       |
| <b>MSNJ Public Health: CARE Leadership<br/>Coalition</b>             | December 20    | Lawrenceville NJ, (609) 896-1766                                       |

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| <b>Advances in Arthritis</b>                            | January 5  | Overlook Hospital, Summit NJ,<br>(609) 896-1901        |
| <b>Biology of Wounds</b>                                | January 6  | UMDNJ-Medical School,<br>Newark NJ, (609) 896-1901     |
| <b>MSNJ Prompt Pay Kickoff Program</b>                  | January 10 | Lawrenceville NJ, (609) 896-1766                       |
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**D A T E**

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| <b>9th Annual Perinatal Ultrasound Symposium</b>           | January 13-14 | Hyatt Regency, New Brunswick NJ, (609) 896-1901 |
| <b>Graduate Medical Education</b>                          | January 20    | UMDNJ-Medical School, Newark NJ, (609) 896-1901 |
| <b>Physicians Conference 2001 Planning Meeting</b>         | January 23    | Lawrenceville NJ, (609) 896-1766                |
| <b>Academy of Medicine of NJ Board of Trustees Meeting</b> | January 24    | Lawrenceville NJ, (609) 896-1901                |
| <b>Stroke: Current Advances, Treatment, and Prevention</b> | January 31    | Union Hospital, Union NJ, (609) 896-1901        |

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| <b>The Multimodular Goiter</b>                                                        | February 4     | UMDNJ-Medical School, Newark NJ, (609) 896-1901              |
| <b>NJ Gastroenterological Society Albert Siegel Symposium</b>                         | February 5     | Saint Barnabas Medical Center, Livingston NJ, (609) 896-1901 |
| <b>MSNJ Council on Legislation</b>                                                    | February 7     | Lawrenceville NJ, (609) 896-1766                             |
| <b>Laparoscopic Surgery for Morbid Obesity</b>                                        | February 8-9   | New York NY, (212) 241-6509                                  |
| <b>The Lymph Node: Speedometer or Accelerator?</b>                                    | February 10    | UMDNJ-Medical School, Newark NJ, (609) 896-1901              |
| <b>Winter CME Festival</b>                                                            | February 13-17 | Penn State College of Medicine, Hershey PA (717) 531-6483    |
| <b>MSNJ Sports Medicine Committee</b>                                                 | February 14    | Lawrenceville NJ, (609) 896-1766                             |
| <b>Current Management of Crohn's Disease</b>                                          | February 16    | UMDNJ-Medical School, Newark NJ, (609) 896-1901              |
| <b>Kessler 13th Annual Review Course in Physical Pain Medicine and Rehabilitation</b> | February 16-25 | Sheraton, Parsippany NJ, (609) 896-1901                      |
| <b>MSNJ Board of Trustees</b>                                                         | February 18    | Lawrenceville NJ, (609) 896-1766                             |
| <b>Carotid Endarterectomy and Angioplasty-Stent Procedures</b>                        | February 23    | UMDNJ-Medical School, Newark NJ, (609) 896-1901              |

## In Memoriam

### S. THOMAS CARTER, MD, FOUNDER OF FAMILY PRACTICE RESIDENCY AND FORMER MSNJ TRUSTEE

*Paul J. Hirsch, MD*



S. Thomas Carter, Jr., MD, a family physician who served on the Board of Trustees of the Medical Society of New Jersey from 1977 to 1978, died at Virtua-West Jersey Hospital on October 9, 2000. He was 72 years old.

A 1953 graduate of Hahnemann Medical College, Dr. Carter was retired and had been living in Moorestown. He was a member of the Camden County Medical Society and of the American Medical Association.

Dr. Carter was the founder of the Tatem Brown Family Practice Residency program for West Jersey Hospital, using his own practice as the core of the

program. He served West Jersey Hospital as chairman of the Department of Family Practice and also as a member of the board of trustees.

During his career, Dr. Carter had clinical teaching appointments at the University of Pennsylvania School of Medicine, Temple University, and Hahnemann University.

He played leadership roles in many medical professional organizations and served as president of the Camden County Medical Society and the New Jersey Academy of Family Practice. In addition, he was an alternate delegate to the American Medical Association from 1986 to 1987.

Dr. Carter is survived by his wife, Barbara Carter; his sons, S. Thomas Carter III and Scott L. Carter; his daughter, Linda L. Carter; and three grandchildren.





## In Memoriam

**Abramson, Solomon**, December 5, 1901-December 5, 1995. Leipzig (1927), Union County, General.

**Bonnet, W. Laurence**, June 28, 1913-January 20, 2000. Hahnemann (1938), Mercer County, Radiologist.

**Carter, S. Thomas, Jr.**, November 15, 1927-October 9, 2000. Hahnemann Medical College (1953), Camden County, Internal Medicine.

**Castellano, Martin**, March 15, 1908-November 7, 1998. Georgetown Medical School (1932), Essex County, Internal Medicine.

**Cummins, James B.**, October 24, 1910-September 16, 2000. Georgetown Medical School (1938), Morris County, Surgery.

**Davis, Thomas C.**, October 8, 1907-June 14, 2000. Columbia University (1931), Essex County, Surgery.

**DeFilippis, Ralph L.**, April 19, 1917-June 30, 2000. St. Louis University (1942), Essex County, General.

**Demarest, Gerald B.**, October 29, 1911-October 22, 1999. University of Chicago (1938), Union County, Internal Medicine.

**Eccleston, Herbert H.**, May 16, 1914. University of Buffalo (1940), Bergen County, Obstetrics/Gynecology.

**Fischer, Robert L.**, January 14, 1936-July 28, 2000. SUNY-Downstate (1961), Bergen County, Psychiatry.

**Garcia, Esther**, December 18, 1934-June 21, 2000. University of Paris (1961), Hudson County, Radiology.

**Giordano, Salvatore**, April 17, 1911-September 27, 2000. Marquette University (1939), Morris County, Surgery.

**Goldman, David L.**, September 3, 1910-August 16, 2000. Anderson College (1937), Hudson County, General.

**Grimes, Vera J.**, September 21, 1918-June 16, 1999. London School of Medicine (1942), Bergen County, General.

**Griswold, Merton L., Jr.**, September 25, 1904-August 6, 2000. Columbia University (1929), Union County, Surgery.

**Holmes, Herbert**, September 17, 1932-July 22, 2000. Royal College of Physicians and Surgeons (1958), Essex County, Obstetrics/Gynecology.

**Kaney, Marie**, April 22, 1911-April 22, 2000. University of Vienna (1936). Essex County, General.

**Kiernan, Patricia A.**, June 3, 1933-August 5, 2000. New Jersey College of Medicine (1960), Morris County, Anesthesiology.

**Krosney, Neil**, March 7, 1938-August 9, 2000. University of Missouri School of Medicine (1965), Monmouth County, Ophthalmology.

**Lilien, Milton**, November 15, 1910-February 1, 2000. University of Iowa (1936), Essex County, Pediatrics.

**Millspaugh, Frederick W., Jr.**, February 25, 1932-November 8, 1998. Temple University Medical School (1957), Camden County, Obstetrics/Gynecology.

**Mintz, Julius**, September 25, 1918-December 13, 1999. Hahnemann Medical College (1945), Somerset County, Internal Medicine.

**Mondsen, Emil**, August 13, 1910-October 12, 2000. Montpellier (1935), Hunterdon County, Diseases of the Chest.

**Netz, Lester W.**, March 1, 1900-February 19, 2000. University of Minnesota (1927), Bergen County, Anesthesiology.

**O'Connor, John P.**, June 4, 1917-August 15, 2000. Jefferson Medical College (1942), Bergen County, Internal Medicine.

**Paisley, Ellwood S.**, September 22, 1916-September 15, 2000. Hahnemann Medical College (1943), Camden County, Internal Medicine.

**Porter, Samuel C.**, May 17, 1933-June 13, 2000. Jefferson Medical College (1958), Gloucester County, General.

**Rieman, Francis E.**, June 17, 1924-June 23, 2000. New York University (1947), Hudson County, General and Surgery.

**Sakson, John A.**, July 5, 1922-February 11, 2000. Hahnemann Medical College (1946), Mercer County, General.

**Salato, Paul J.**, February 23, 1950-October 1999. University of Juarez (1983), Passaic County, Internal Medicine.

**Siegel, Jack G.**, December 31, 1908. Long Island University (1935), Essex County, Traumatic Surgery.

**Stokes, Donald E.**, December 12, 1915-July 10, 2000. Cornell (1940), Essex County, Obstetrics/Gynecology.

**Sussman, Irvin**, April 23, 1918-March 2, 1998. Hahnemann Medical College (1943), Cumberland County, Internal Medicine.

**Taylor, Wilber F.**, November 11, 1923-July 6, 2000. Hahnemann Medical College (1948), Essex County, Anesthesiology.

**Thompson, John J.**, September 18, 1941-August 15, 1999. Bowman Gray Medical School (1943), Essex County, Radiology.

**Tuly, Ralph**, 1915-June 24, 2000. Long Island College of Medicine (1938), Essex County, General and Obstetrics/Gynecology.

**Wise, John S.**, October 21, 1914-October 24, 1999. University of Pennsylvania (1941), Mercer County, Surgery.

**Zbar, Joseph E.**, November 9, 1910-March 23, 1995. Queen's University (1936), Hudson County, Otolaryngology.

**Zitani, Alfred M., Sr.**, 1899-April 7, 2000. George Washington University (1924), Hudson County, Neuropsychiatry.

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# It's Time for Consolidation

*Joseph A. Riggs, MD*

A major concern in medicine during these rapidly changing times is physician apathy, and nothing leads to more apathy than physicians who are underrepresented or unrepresented in their organizations. The basis for the strength and effectiveness of organized medicine in this country has been the county-state-national alignment. This has functioned well from the bottom up, as long as county societies, on the local grassroots level, were inclusive, active, and thriving.

However, the membership base has continued to erode in geographically based societies, while the costs to recruit and retain members have grown. These societies are struggling to attract new members and then to meet the expectations of these members.

The specialty societies, however, have shown strong growth (90% to 95%), while the county and state societies have shown a decline (30% to 35%) in participation. The pressures on physicians to boost practice productivity and patient revenue make it increasingly difficult to recruit new members and new leaders. This erosion of membership is already causing a decrease in organizational revenues and will lead to smaller administrative staffs and downsizing of services and activities. Since most county societies do not have alternative sources of income, they will no longer be able to do all things for all people and will eventually fade out of existence.

Many county societies are approaching serious economic defaults and will no longer be able to function as active participants in the medical community. With new technology and improved communications, the time has come to change to a different structure to represent medicine. It is time to consolidate!

Consolidation of county societies is occurring all over the country. As a matter of fact, three state medical societies are now in discussions to consider merging with each other.

We should realize and accept the fact that there can no longer be 21 separate county societies in New Jersey. Instead there should be three regional medical societies, one for south Jersey, one for central Jersey, and one for north Jersey.

The county societies that currently exist could still retain their identity by becoming chapters of the regional societies. All mailings, other communications, planning, and procedures would come from the regional office. Chapter meetings could be consolidated into one regional meeting. A regional executive committee would consist of members from each chapter and meet monthly to identify problems, share solutions, and promote membership. They would also carry out key contact assignments with legislators, discuss legislative issues, and deliberate on any other business that comes before the regional society. Most important, there will be a combined dues structure, which would be lower than the individual county societies are required to charge while allowing for improved services.

Perhaps there has not yet been enough need, necessity, or even suffering to carry out this restructuring. However, it is better to change now than to wait for eventual bankruptcy, leading to no representation at all. It is, indeed, time to consolidate!

*Joseph A. Riggs is a past president of MSNJ and is currently a member of the Board of Trustees of the American Medical Association. His opinions do not necessarily reflect those of the AMA or any other organization.*





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